the Canadian Nurse

VOLUME 59 • NUMBER 4

MONTREAL

APRIL 1963

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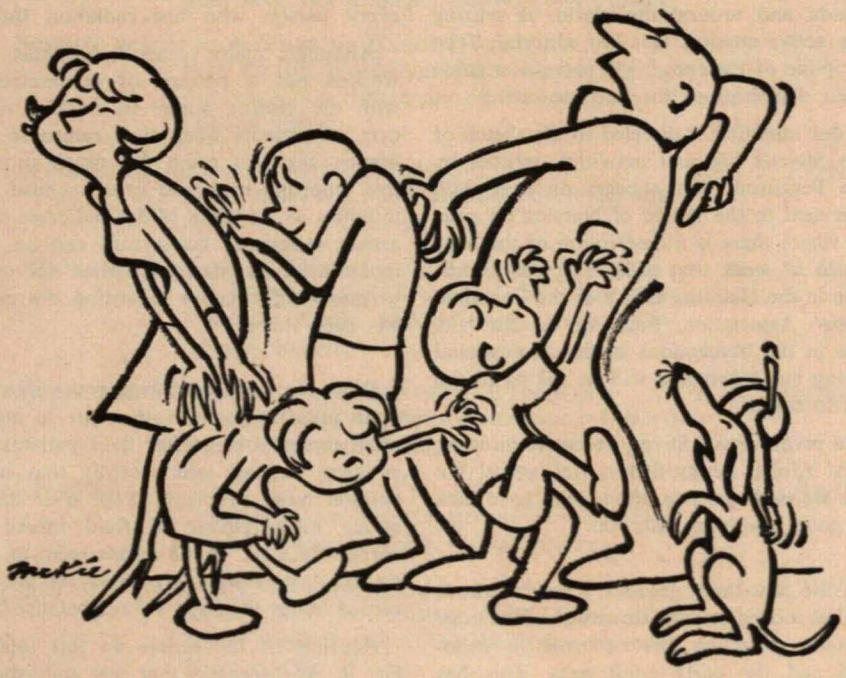

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Between Ourselves

There is an aura of sadness in official nursing circles this month for M. Pearl Stiver, "Penny" to thousands of nurses in Canada and around the world, is retiring from active nursing. Her last editorial, "The Discipline of Patience," will serve as a guide in our deliberations for years to come.

Your attention is directed to the sketch of Miss Stiver's life and activities, written by June Ferguson, that appears on page 329. Turn next to the World of Nursing on page 361 where there is a description of the busy pattern of work that is an everyday occurrence in the National Office of the Canadian Nurses' Association. Each of us can take pride in the tremendous strides professional nursing has taken and will be taking in the days to come.

Au revoir, Pearl Stiver, executive director, CNA! Aloha, Penny Stiver, free agent! We hope we shall see you often. May good luck and good health go with you.

* * *

In the past three decades, Canada's death rate has moved steadily downward. The most dramatic reduction has occurred in childhood and the early adult ages. This has meant that there has been an increase in the number of people in the middle and older age groups where a different group of diseases appears. Among these persons, cancer and diseases of the cardiovascular-renal systems account for a substantially large proportion of all deaths.

April is usually designated as the fund-raising cancer campaign month. Organized in 1938, the Canadian Cancer Society has done a tremendous job of spurring potential patients to seek early diagnosis. The voluntary contributions made to the Society provide the major source of funds for the basic research program of the National Cancer Institute of Canada. It merits your unstinting support.

Dr. Bryant's discussion of the present-day methods of treating malignant diseases in general plus the informative material on leukemia that Dr. Baribeau has written will give every nurse a breadth of knowledge that will prove invaluable in your work with patients, their families and friends. While the possible radiation hazard in diagnostic radiology does not involve the nurses providing patient care, the carefully designed protection measures give reassurance to every person who has radiation therapy.

Although many general hospitals have worked out a pattern of communication with the visiting nurses in relation to the care of patients when they return to their homes, there is room for much more of this reporting back and forth in most communities as Lorraine Miller indicates in her article. Adequate home care can be given much more satisfactorily when all of the pertinent information regarding the patient has been shared.

* * *

What do surgeons consider the most difficult point in postoperative care to impress upon those looking after their patients? An eminent surgeon said recently that in his opinion more problems arose over the accurate measurement of fluid intake and output. Said he, "some nurses seem to think we are just being fussy when we are concerned about the body's fluid balance."

Reprints of the article on this topic by Dr. R. V. Moralejo that was published in our December 1962 issue are available at the modest price of five cents each, prepaid. Send your order to the Journal office promptly as the supply of reprints is limited.

* * *

In many parts of Canada the end of this month sees men with moving vans working day and night. If you are moving now or at any time in the future, please send us your change of address as soon as possible. To avoid possible errors, we must have *your registration number and the province in which you are registered* as well as your old and new addresses. You have no idea how many duplications of names, even in the same community, are on our mailing list. It really helps when you attach the label from one of your journals.

One will rarely err if extreme actions be ascribed to vanity, ordinary actions to habit, and mean actions to fear.

— NIETZSCHE

THE CANADIAN NURSE

VOLUME 59 **NUMBER 4**

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327 THE DISCIPLINE OF PATIENCE ..... *M. P. Stiver*
Miss Stiver is Executive Director, CNA Ottawa.

328 SCHOOL FOR SENIOR NURSING EXECUTIVES ..... *A. E. Griffin*
Miss Griffin is Assistant Professor in Nursing Administration, University of Western Ontario, London, Ont.

329 A NAME SYNONYMOUS WITH NURSING ..... *J. Ferguson*
Miss Ferguson is Public Relations Secretary with the CNA.

331 MODERN METHODS OF TREATING MALIGNANT DISEASES ..... *A. J. S. Bryant*
Dr. Bryant is the Director of the Allan Blair Memorial Clinic, Saskatchewan Cancer Commission, Regina.

338 RADIATION PROTECTION IN DIAGNOSTIC RADIOLOGY ..... *P. A. Macdonald*
Dr. Macdonald is Director, Radiation Laboratories, Winnipeg, Manitoba.

342 LEUKEMIA ..... *G. Baribeau*
Dr. Baribeau, a Hematologist, is on the staff of Hôpital St-Joseph, Three Rivers, Quebec.

345 NURSING CARE IN LEUKEMIA ..... *D. Willson*
Miss Willson is Assistant Head Nurse of a public medical floor, The Wellesley Hospital, Toronto, Ont.

347 A PATIENT WITH HODGKIN'S DISEASE ..... *B. Hartley*
Miss Hartley completed this nursing care study while she was a second year student in the School of Nursing, Kingston General Hospital, Kingston, Ont. She received Honorable Mention in this year's Macmillan Award Competition.

352 THESE FOUR ..... *L. F. Miller*
Miss Miller is District Director, Victorian Order of Nurses, Saskatoon, Sask.

355 NURSING CARE OF THE PATIENT WITH ADVANCED CANCER ..... *L. Richardson*
Miss Richardson was a senior student in the School of Nursing, Saskatoon City Hospital, when she prepared this study.

359 A HOSPITAL POSTPARTUM TEACHING PROGRAM ..... *G. M. Hornick and E. M. Howard*
Miss Howard is Director of Nursing, Miss Hornick the obstetrical instructor at the New Mount Sinai Hospital, Toronto, Ont.

365 NURSING WITH INHS IN THE SASKATCHEWAN REGION ..... *L. J. Whiteford*
Miss Whiteford, formerly Regional Nursing Officer, Saskatchewan Region, is now Consultant in Nursing Education, Medical Services, National Health and Welfare.

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Executive Director and Editor: Margaret E. Kerr, M.A., R.N.

Associate Editor: Jean E. MacGregor, B.N., R.N.

Assistant Editor (English): Virginia A. Lindabury, B.Sc.N., R.N.

Assistant Editor (French): Claire Bigué, B.Sc., Ed. Inf., I.L.

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Random Comments

Dear Editor:

I would like to direct your attention to the article on mongolism which appears in the November 1962 issue. Dr. Chicoine states: "While the cells of the normal individual have 48 chromosomes . . . " Recent publications in human genetics indicate that the individual has only 46 chromosomes.

I especially enjoyed this issue of *The Canadian Nurse* because of the pediatric articles.

E. MOORE, Saskatchewan

Dear Editor:

I am always glad to receive the *Journal* and read every issue with much interest.

I would like to question two statements made by Dr. Chicoine in the article "Childhood Deformities," Nov. 1962 issue.

In the section, *Hydrocephalus*, the following appears: "Cerebrospinal fluid is secreted in the lateral ventricles and absorbed into the general circulation in the cerebral subarachnoid space." Is not cerebrospinal fluid secreted by the tela chorioidea of all four ventricles?

Under the heading *Mongolism*, the author states: "While the cells of the normal individual have 48 chromosomes, most individuals affected by mongolism have only 47." In 1956, Tjio and Levan established that the normal number of human chromosomes was 46. Since that time, the number — 46 — has been reconfirmed and accepted.

MARGARET C. SPRINGETT, Sask.

**The original article from Dr. Chicoine stated the normal number of chromosomes as 46. Unfortunately, through error, this appeared as 48 in the English issue.* Ed.

Dear Editor:

May I take this opportunity to commend you on your very informative articles such as the series on Pediatrics in the November, 1962 issue.

MARGARET MAKI, Vancouver, B.C.

Dear Editor:

The Canadian Nurse is supposed to be Canada's nursing journal. Surely to goodness the *Journal* could put itself out occasionally and have a section in the magazine that would help improve those of us who remain in the home. Some subjects might consist of casualties at home, first aid, so-

ciology, psychology — especially child psychology — parent controls, etc. I am sure this would be one way to keep the busy nurse at home interested in her profession.

(Mrs.) DOREEN KUZMICH, Paris, Ontario

Dear Editor:

In growing circles of discontent the common thought is being voiced that something is wrong in nursing. Graduates who were students of the twelve-hour era feel that today's eight-hour shift is inadequate to teach the students much of anything. This attitude is one that stagnates the forward moving progress of our profession.

The red tape of today's hospital organization seemingly has placed the young nurse in the position where, in fear of critical supervisors, she forgets her first intention of caring for the patient. Lights go unanswered because the student has been told to have all the lunch trays distributed by noon. The patient waits for a bedpan while the student goes around checking draw sheets to make sure that they are 13 inches from the top of the bed.

Incidents such as these are no longer isolated occurrences. They are frequent and disrupting in the familiar hospital scene. Why should this be so?

Too often we see the primary nursing care being given by the nursing assistant who, though less thoroughly trained for patient care and bedside nursing, is performing the art while the nurse is busy doing "desk work" — ordering linen supplies, sterile tubes, dressing trays, etc. Obviously, it is unfair to say that these jobs are unimportant for without adequate supplies no hospital ward can function smoothly. Yet nurses did not train professionally in order to check supply cupboards. Nor do we like to see nursing care being done entirely by nursing assistants. When we approached nursing it was at the bedside. In our minds was the thought that the nurse was the gentle, humanity-loving bearer of the candle.

How changed the scene of today! The nurse is busy, pen in hand, organizing her time-tables, sorting slips of paper, attaching them to charts, ordering supplies, guiding students, making rounds with doctors, and keeping a watchful eye on everything. Too often the poor head nurse, loaded down with these responsibilities, actually misses her chance to improve things. How often do we see young student nurses doing such menial tasks as washing table tops, dusting beds, etc.? Almost any person could do

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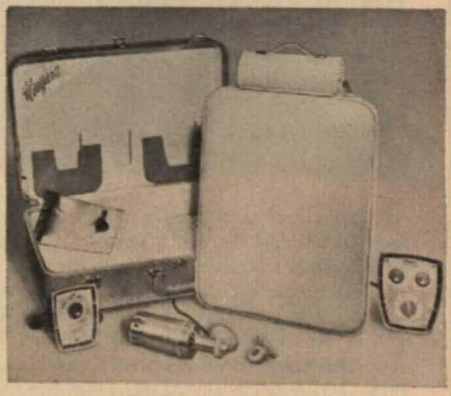

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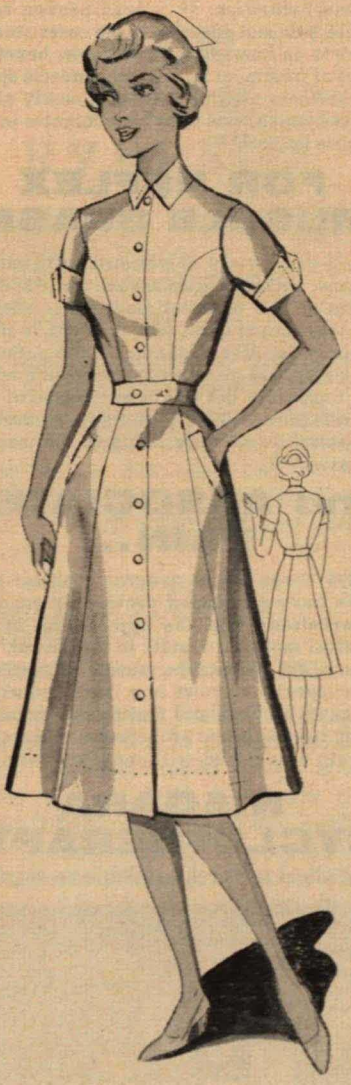

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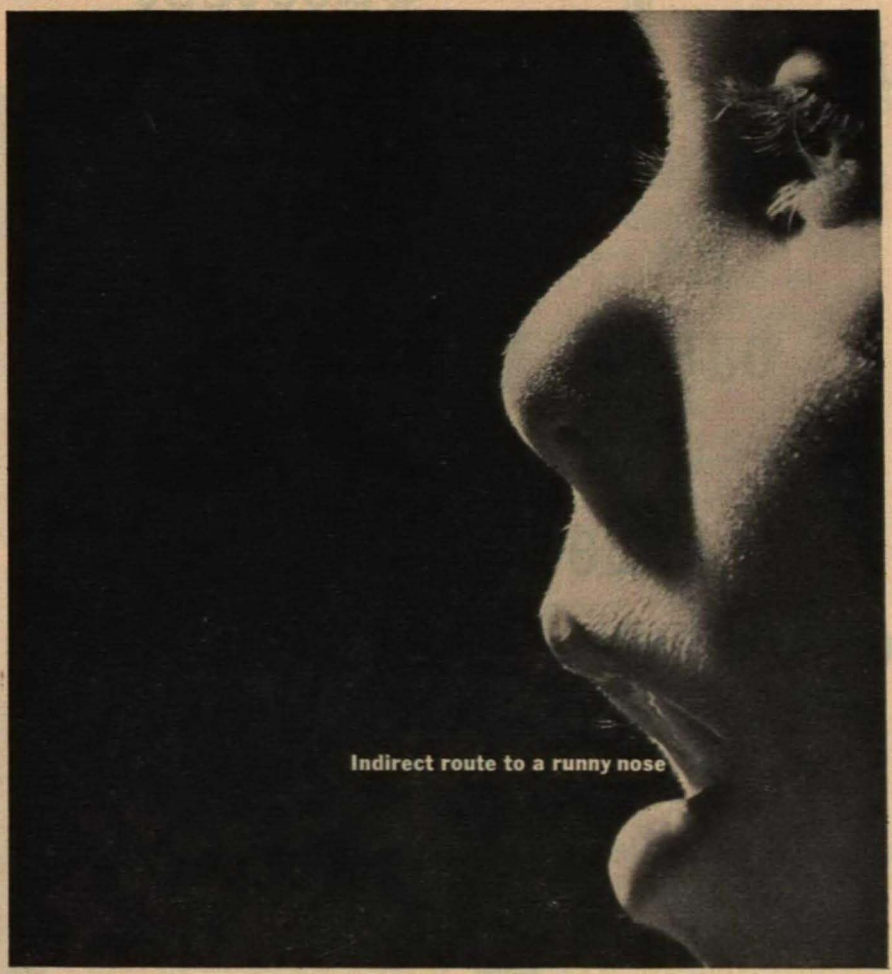
If the director of nursing is forward thinking, she is forever searching out the flaws in the system and making the hospital run more smoothly, happy and free from fear. If the director is authoritarian and old-fashioned she sometimes fails to open her eyes to the sights around her. Lost in her protected viewpoint she does not realize that the hospital is not the essence of perfection.

What can be done about it? Organization, forward thinking, kindness are the keys. Correction does much, but encouragement does much more. If each member on staff does her share, the atmosphere will improve, the tasks become shorter and all concerned will be happier.

FRANCINE MCCARTHY, New Brunswick



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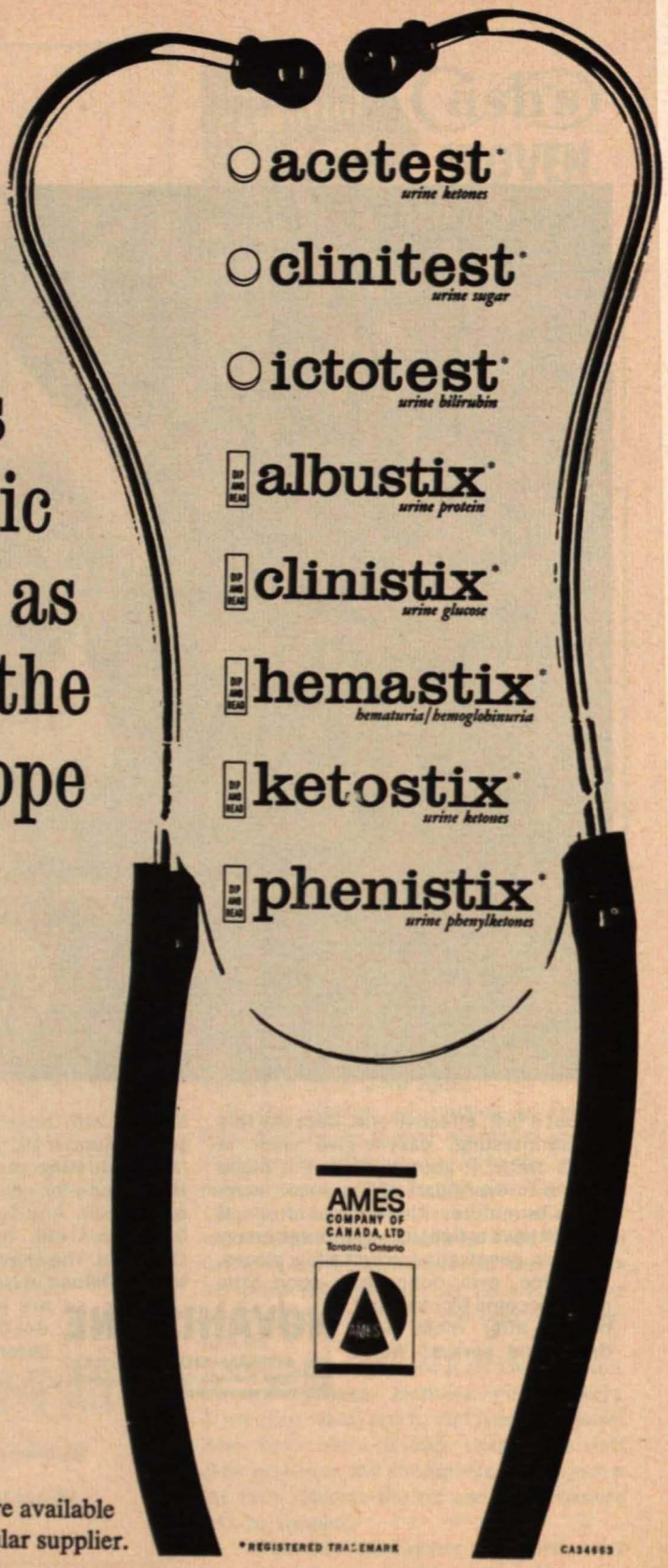

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Random Comments

Dear Editor:

I would like to direct your attention to the article on mongolism which appears in the November 1962 issue. Dr. Chicoine states: "While the cells of the normal individual have 48 chromosomes . . . " Recent publications in human genetics indicate that the individual has only 46 chromosomes.

I especially enjoyed this issue of *The Canadian Nurse* because of the pediatric articles.

E. MOORE, Saskatchewan

Dear Editor:

I am always glad to receive the *Journal* and read every issue with much interest.

I would like to question two statements made by Dr. Chicoine in the article "Childhood Deformities," Nov. 1962 issue.

In the section, *Hydrocephalus,* the following appears: "Cerebrospinal fluid is secreted in the lateral ventricles and absorbed into the general circulation in the cerebral subarachnoid space." Is not cerebrospinal fluid secreted by the tela chorioidea of all four ventricles?

Under the heading *Mongolism,* the author states: "While the cells of the normal individual have 48 chromosomes, most individuals affected by mongolism have only 47." In 1956, Tjio and Levan established that the normal number of human chromosomes was 46. Since that time, the number — 46 — has been reconfirmed and accepted.

MARGARET C. SPRINGETT, Sask.

**The original article from Dr. Chicoine stated the normal number of chromosomes as 46. Unfortunately, through error, this appeared as 48 in the English issue.* Ed.

Dear Editor:

May I take this opportunity to commend you on your very informative articles such as the series on Pediatrics in the November, 1962 issue.

MARGARET MAKI, Vancouver, B.C.

Dear Editor:

The Canadian Nurse is supposed to be Canada's nursing journal. Surely to goodness the *Journal* could put itself out occasionally and have a section in the magazine that would help improve those of us who remain in the home. Some subjects might consist of casualties at home, first aid, so-

ciology, psychology — especially child psychology — parent controls, etc. I am sure this would be one way to keep the busy nurse at home interested in her profession.

(Mrs.) DOREEN KUZMICH, Paris, Ontario

Dear Editor:

In growing circles of discontent the common thought is being voiced that something is wrong in nursing. Graduates who were students of the twelve-hour era feel that today's eight-hour shift is inadequate to teach the students much of anything. This attitude is one that stagnates the forward moving progress of our profession.

The red tape of today's hospital organization seemingly has placed the young nurse in the position where, in fear of critical supervisors, she forgets her first intention of caring for the patient. Lights go unanswered because the student has been told to have all the lunch trays distributed by noon. The patient waits for a bedpan while the student goes around checking draw sheets to make sure that they are 13 inches from the top of the bed.

Incidents such as these are no longer isolated occurrences. They are frequent and disrupting in the familiar hospital scene. Why should this be so?

Too often we see the primary nursing care being given by the nursing assistant who, though less thoroughly trained for patient care and bedside nursing, is performing the art while the nurse is busy doing "desk work" — ordering linen supplies, sterile tubes, dressing trays, etc. Obviously, it is unfair to say that these jobs are unimportant for without adequate supplies no hospital ward can function smoothly. Yet nurses did not train professionally in order to check supply cupboards. Nor do we like to see nursing care being done entirely by nursing assistants. When we approached nursing it was at the bedside. In our minds was the thought that the nurse was the gentle, humanity-loving bearer of the candle.

How changed the scene of today! The nurse is busy, pen in hand, organizing her time-tables, sorting slips of paper, attaching them to charts, ordering supplies, guiding students, making rounds with doctors, and keeping a watchful eye on everything. Too often the poor head nurse, loaded down with these responsibilities, actually misses her chance to improve things. How often do we see young student nurses doing such menial tasks as washing table tops, dusting beds, etc.? Almost any person could do

Cycloid therapy in the joints of chronic rheumatoid arthritics: "... was proven to be simple, safe and effective in the cases studied. There is an immediate, repeatable, beneficial effect of treatment in that pain, muscle spasm and stiffness are diminished in nearly all instances which lasts from forty minutes to two or more hours."*

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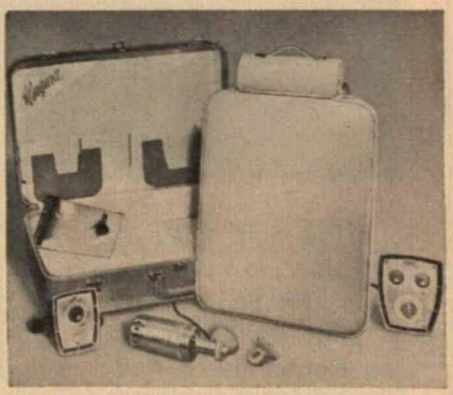

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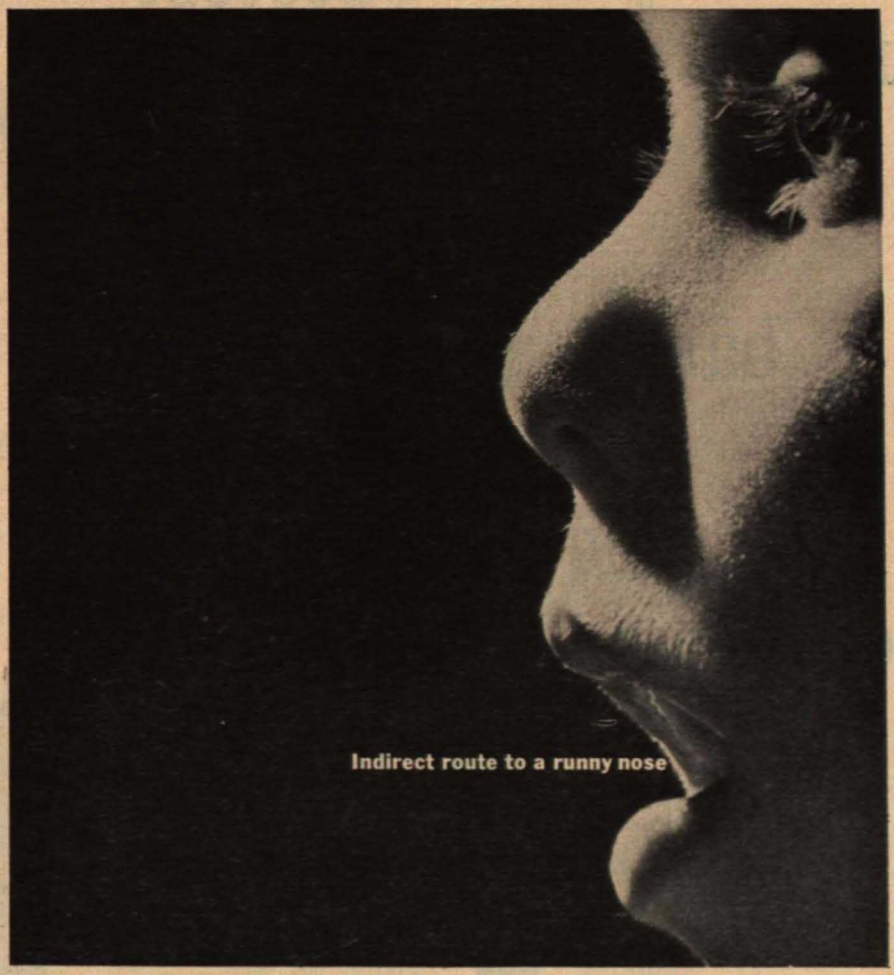
these jobs. Perhaps we must say more emphatically — let these tasks be put in the hands of persons less skilled than the student of nursing or the Registered Nurse. Let the skilled nurse use any spare time she may have at the patient's bedside giving him the chance to relate his fears and helping to explore them in the open.

If the director of nursing is forward thinking, she is forever searching out the flaws in the system and making the hospital run more smoothly, happy and free from fear. If the director is authoritarian and old-fashioned she sometimes fails to open her eyes to the sights around her. Lost in her protected viewpoint she does not realize that the hospital is not the essence of perfection.

What can be done about it? Organization, forward thinking, kindness are the keys. Correction does much, but encouragement does much more. If each member on staff does her share, the atmosphere will improve, the tasks become shorter and all concerned will be happier.

FRANCINE MCCARTHY, New Brunswick



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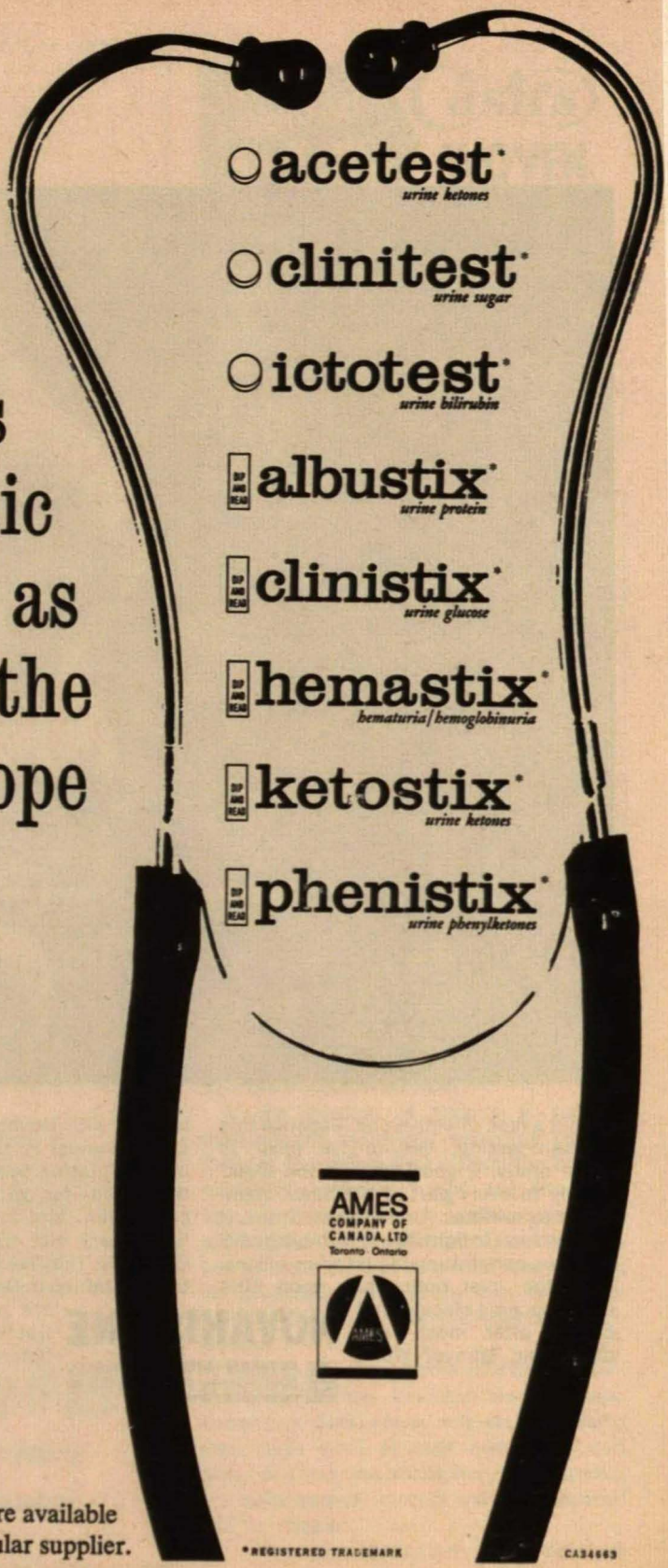

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VOLUME 59 MONTREAL, APRIL 1963 NUMBER 4

The Discipline of Patience

On September 20, 1961, the world lost one of its great citizens in the person of Dag Hammarskjold.

The Right Reverend Ernest S. Reed, Bishop of Ottawa, put his finger on the secret of Dag Hammarskjold's greatness when he said "He possessed the discipline of patience." It was his ability to bring peoples together; to, in his own words, "prick the balloon of emotion" and make "tensions creative" that enabled him to bring the United Nations to its highest level of efficiency. In effect, he was enabling nations to deal effectively with change and to work and plan harmoniously with one another.

Change is characteristic of life today and the practice of nursing is no exception. One of the changes with which the nursing profession is concerned is the transfer of functions from one worker to another. Much that the nurse previously did for the patient is now done by the nursing assistant. Similarly, much that was once considered medical practice has been transferred to nursing. Perhaps these changes are inevitable. If they are in the interest of patient care and effective health services can changes be denied? The essential thing is that the nurse keeps close to the patient and close to the community.

With respect to the transfer of duties from one category of worker to another, it is hoped that the procedure suggested in the Canadian Nurses' Association Brief to the Royal Commission on Health Services will be followed, namely, that study precede the transfer of activities and that

Special consideration be given to the legal

implications with regard to medical practice both for the safety of the patient and the protection of the nurse.

The important thing is that patients, the Canadian people, receive the best possible care.

Towards this objective the Canadian Nurses' Association has pressed for higher standards of nursing education and practice. This does not mean that the good of the past is lost sight of or that the contribution of nurses now in practice is forgotten. Far from it! Change involves two things — the past and the future. That which is good, creative and forward-looking in the past provides an opportunity to see new horizons for the future.

But there are other factors which will affect nursing in Canada in the days ahead. Many of the great social changes, were outlined by Professor Bernard Blishen in his address "Social Change in Canada" at the 31st Biennial Meeting, Canadian Nurses' Association, in June of last year. He spoke of the changes in population growth in Canada, the changes in ethnic and religious patterns, the rural-urban shifts and their consequent effects on the "occupation structure." He referred also to the higher level of education of the average Canadian — all these things and many more. What will be their effect on nursing practice?

Nursing will change with sociological change. Those who guide its destiny will require wisdom so that knowledge will serve a useful purpose and tensions when they arise, as well they may, will prove creative. The "Discipline of Patience" which enabled the Secretary-General of the United Nations to bring nations of the world together in conciliation, will enable the nursing profession to find its place in the country's health program.

M. PEARL STIVER,
Executive Director,
Canadian Nurses' Association

School for Senior Nursing Executives

AMY E. GRIFFIN, M.A.

In his book "Education for a World Adrift," Sir Richard Livingstone has observed:

> Youth studies but cannot act; the adult must act and has no opportunity of study; and we accept the divorce complacently. But action and thought, living and learning naturally belong together and should go hand in hand . . . Some day . . . we shall give everyone a chance of thinking about life when he is facing it and about its problems when he has to solve them.[1]

To provide just such an opportunity in their professional lives, for nurses functioning in senior administrative positions, the School of Nursing of the University of Western Ontario is planning a **School for Senior Executives** offering a concentrated program to extend from June 17 to 29 this year.

It is the belief of our School that the administrative process has certain common denominators applicable to any enterprise but that its implementation varies in certain vital respects dependent upon the administrator, the nature of the enterprise to be administered and the environment in which it operates. In line with this belief the opportunity to attend the School for Senior Executives will be made available to directors of nursing service, assistants and supervisors in hospitals and other health agencies; directors of nursing education and their assistants; executives and consultants in professional nursing organizations. Selection of applicants will provide for a representative group from these various fields of nursing. It is hoped, as well, that the geographic distribution of enrollees will permit a sharing of ideas and a concerted

(Continued on page 368)

A NAME SYNONYMOUS WITH NURSING

JUNE FERGUSON

April 30th, 1963, marks the end of a decade of devoted service to CNA by a woman whose first thoughts about a career didn't include nursing.

As Pearl Stiver, affectionately known to hundreds of nurses throughout the association as "Penny," prepares to vacate the office of executive director, she recalls vividly her school days in Stayner, Ontario, where she made plans to become an artist. Lacking enough funds for the four-year course at the Ontario College of Art changed those plans. "It was then," she said, "that I turned to the career that has brought me great satisfaction and no regrets. I haven't thought about art, beyond buying a box of paints, since."

Following graduation from Toronto Western Hospital, she studied public health nursing at the University of Toronto and received her Bachelor of Science degree from Columbia University. She later worked with the VON and the Ontario Department of Health on their V.D. Program. In 1949, she was appointed director of public health nursing in Ottawa. During these years she was active in her provincial association and at the time of her appointment to CNA had become vice president of RNAO as well as vice president of the Ontario Public Health Association.

It was in the fall of 1952 that Penny Stiver left for Montreal, where National Office was then located. With a staff of five and a membership of 30,000, she set her mind to the task of the CNA, conscious of her great responsibility to the nurses of Canada.

It wasn't long after her arrival there that pressure was brought to bear on the association, by nurses in national positions in Ottawa, to move CNA headquarters to the capital. The late Agnes McLeod, then director of nursing with the Department of Veteran's Affairs, was one of the prime backers

(Paul Horsdal Ltd., Ottawa)

PEARL STIVER

of the move. She felt, as did the others, that CNA, to accept its rightful place in the national picture as the recognized voice of nursing, should be more readily available to the Federal Government and government agencies. These feelings were expressed in the form of a brief presented to the general meeting of the association in Banff. December, 1954 saw CNA become the 125th national organization to have its headquarters in Ottawa.

1954 also brought to Penny a strong link with her past. With the election of the eighteenth president, she found herself, for the second time in her life, serving under Gladys Sharpe. It was during her student days at Western that she had first met her. Recalling those days with fond memories, she said it was to Gladys Sharpe and Rahno Beamish she owed all she knew about nursing.

The four presidents that followed Gladys Sharpe into office (Trenna Hunter, Alice Girard, Helen Carpenter and Electa MacLennan, as well as Penny's first president, Helen McArthur) agreed she had learned well. "Penny Stiver's appointment truly reflected her continuing interest in nursing problems throughout the world. Her warmth, understanding and inspiration were felt by all who came to know her."

In the next eight years Penny Stiver never unpacked a suitcase. TCA knew her as "the most travelled woman in the country." She was ready on a moment's notice to travel anywhere her job required her to be, and it was this personal contact with the nurses throughout the world that brought her the greatest joy.

These years were probably the most active in CNA's history. They saw a vast growth in association membership; the birth of a retirement plan for nurses; the first Canadian stamp on nursing; a pilot project for the evaluation of nursing schools; the first Canadian Conference on nursing; and the launching of the Canadian Nurses' Foundation. Penny, nevertheless, found time to give thought and a helping hand to those less fortunate than herself. Her activities outside CNA, too, reflected her concern in helping others. As president of the Zonta Club this year she was a driving force in creating a residence for retired women with moderate means.

A new career now awaits Penny Stiver. She leaves in a few weeks for Lake of Bays where she and former VON director in chief Christine Livingston will open a craft shop. When asked how she felt about leaving the association she has spent ten years in helping to build, she had this to say: "Though I'm looking forward to my new venture, I leave CNA with mixed feelings. I have always regarded it an honor to have had the opportunity and privilege to represent a profession that that has made such a great contribution to our world today. There is still a great challenge ahead of it, but with understanding, wisdom and humility, and with full appreciation of the strength in others and the weaknesses in ourselves, this challenge will be met."

With Penny Stiver go the blessings of every canadian nurse. Her name will long be remembered in the nursing profession.

Canadians can point with pride to the Siblin Vocational Training Centre south of Beirut, Lebanon. It was made possible by gifts from Canada. It was opened in September 1962, and will have an enrolment of approximately 300 refugee children. Among the skills they will be taught will be the radio-TV, architectural, draughtsman, electrical, plumbing, sheet metal working, carpentry, welding and auto mechanic trades. The Canadian government contributed $450,000 towards this school. The Canadian World Refugee Year Committee and the Canadian Junior Red Cross raised another $223,000 for the Siblin Centre. The Canadian Junior Red Cross has committed itself to contribute $50,000 in a two-year period to supply scholarships for 50 students at the Siblin Centre. Of this amount $25,000 has already been raised and handed over to UNRWA for this purpose. The Canadian Junior Red Cross has no doubts that Canada's children will meet their commitment and raise the remaining $25,000 in their 1962-1963 school year.

—News of Red Cross, Sept., 1962

Modern Methods of Treating Malignant Diseases

A. J. S. BRYANT, M.D.

A comprehensive resumé of the treatment available to victims of various forms of cancer with indication of comparative effectiveness.

Introduction

Successful management of malignant diseases continues to be dependent for cure on the well-recognized modalities of radical surgical extirpation or radical radiation therapy. In some instances, a combination of both is found more effective than either alone. That increasing, though limited, over-all success has been achieved by the application of these measures is attested by many statistical reports. In Saskatchewan, this general improvement is demonstrated[1] by a five-year survival figure of 53 per cent for all patients with cancer during the period 1945-52, compared with 49 per cent, during the period 1932-44. These figures are based on a comprehensive knowledge of 90 per cent of all patients with cancer in the province and a loss to follow-up of less than 0.4 per cent of all patients seen.

Though these figures are modestly encouraging, they do not permit complacency but rather pointedly define the need for a more aggressive approach, utilizing both old and new concepts of management in an imaginative manner to produce better results. Let us examine some of the current treatment measures to learn their medical indications, expectations and limitations and, in particular, let us discover how the nursing profession may assist in the care of patients undergoing these treatment measures.

Treatment by Surgery

It is beyond the scope of this article to discuss the intricacies of radical extirpative "cancer surgery," except to say that remarkable feats of technical accomplishment are occurring every day. Many of these are successful. There is no doubt that skilled nursing attention in the preoperative and postoperative periods, as well as the competent assistance of operating room nurses, play a significant part in the teamwork that makes these successes possible.

However, further advancement in the control of cancer by these measures alone is not likely to transpire to any significant degree. As Dr. John R. Heller, director of the National Cancer Institute of the United States has stated,[2] "gains from now on in cancer surgery will be fractional. We have pulled the bowstring back about as far as it will go."

Treatment by Radiation Therapy

History

The discovery of X-rays by William Roentgen of Wurtzburg in 1895 ushered in the new science of radiology. Then, through the systematic study of natural fluorescence and phosphorescence, Henri Becquerel, of France, discovered natural radioactivity in 1896. It remained for Pierre and Marie Curie of Paris to successfully isolate radium in December 1898. In 1934, artificial radioactivity was first produced by Irene Curie and her husband, Frederick Joliot, who bombarded atomic nuclei with fast moving particles, thus disturbing the nuclear balance. In an effort to re-establish the balance of nuclear forces, there was emitted a

particle, or gamma ray, or both, of artificially produced radioactivity. Thus any element may become radioactive and is then known as a radioactive isotope.

Momentous discoveries such as these made possible the progressive development of modern radiation therapy and nuclear medicine.[3]

Early in the investigation of the new science, the effect of roentgen rays on the skin was observed. In 1901 Becquerel accidentally developed an erythema of the skin from exposure to radium carried in his pocket. Almost immediately these rays were employed for the treatment of many diseases of the skin and other organs, including cancer. As a result of indiscriminate use, some patients and many physicians suffered serious skin changes or hematologic disorders, some of which ultimately ended in cancer. Now it is known that the curative effects of radiation are due to the selective action of these rays on cancer cells. Hence, when a suitable dosage is accurately delivered, cancer cells will be destroyed but the normal surrounding cells will not be irreparably damaged. In time, the latter will recover their functional capacity and will restore tissue continuity by forming scar tissue.

An accurate measurement or unit of dosage had to be discovered and then methods devised to direct radiation with precision to the site of malignant tumors. The first requirement was accomplished when the "r" or roentgen unit was accepted in 1928, as applied to X-rays, and extended to include the gamma rays of radium in 1937.

The second requirement was largely developed by physicists who introduced, and continued to perfect, accurate methods of calculating dosage at depth in tissues, advantageous distribution or combination of X-ray fields and radium sources, as well as new, more reliable and more powerful equipment.

Conventional radiation therapy

Conventional present day X-ray equipment, operating at 220-280 kilovolts, frequently utilizes multiple cross-firing fields to deliver adequate dosage to tumors at depth. When large fields were used, it was found that the patient's constitution would not tolerate the required dosage. Radiation sickness and leucopenia resulted from exceeding the whole body tolerance (or integral-dose). As a result smaller multiple fields were used to reduce the integral-dose, yet keep the local tumor-dose high. The limiting factor then was the local tissue (skin) tolerance.

Supervoltage therapy

To improve these tolerances, more powerful X-ray equipment has been manufactured some of which produces X-rays at energies of several hundred million volts. The advantages are greater penetration and a greater percentage of rays reaching tissue at depth. In addition the absorption of X-rays in bone and soft tissues becomes almost equal, whereas at lower voltages, there may be two or three times greater absorption in bone. Thus, at higher energies, bone and cartilage are spared the danger of radiation necrosis.

A useful machine of this type is the Betatron: one was installed in the University of Saskatchewan in 1948. Operating to produce X-rays with an energy of twenty-five million volts, it causes little or no effect on the skin but yields the highest dosage at 3-5 cm. beneath. Hence, homogeneous irradiation of deep cancers is possible, using two or more cross-firing beams.

Another very effective tool of the radiotherapist is the Cobalt 60 Teletherapy Unit, which has gained worldwide acceptance since its introduction in 1951. It has many of the advantages of the Betatron but, in addition, is much less cumbersome, requires less maintenance and is economical to purchase. Chemical cobalt, made radioactive by exposure over many months within an atomic reactor, forms a source of radiation equivalent to X-rays produced at two million volts. This source must be encased in a large container of lead with a window at one side through which the rays are directed to the patient. Mechanical devices permit stationary or moving (rotational) treatment applications.

Radiation reactions

The biological effects of radiation are the result of ionization within the tissues that have absorbed the rays.

This causes a series of visible changes, best observed in the skin, called the local radiation reaction. These changes pursue a definite course. First, there is a faint, often transient, blush occurring within 24-48 hours. Then a progressive congestion and redness occur. The skin may remain dry or may later develop a moist desquamation. In rare instances a vesicular eruption may form. Epilation of hair or beard will occur. This maximum reaction is reached about 2-3 weeks after therapy begins. A sense of warmth or constant mild to moderate discomfort may be noted. Resolution progresses to healing over approximately the same time interval. Tanning is observed which may fade quickly or slowly. In 3-6 months the epithelium appears thinned; telangectatic blood vessels are noted; shrinkage and scarring of subepithelial tissues occur. These areas will always remain sensitive to heat, cold or minor trauma. When radiation therapy is required for large volumes of tissue in the thorax or abdomen, a general radiation reaction of variable degrees of severity will occur. In most people this consists first of anorexia with nausea and vomiting likely to develop later. If these symptoms persist with any severity, the completion of treatment will be prevented.

More serious side effects may occur if special sites require high dosage irradiation. Leucopenia, thrombocytopenia and anemia may follow treatment of the blood-forming organs, spleen and lymph nodes. Gastroenteritis or bladder hypertonicity with frequency and tenesmus sometimes accompany abdominal radiation, as do gonadal suppression and atrophy if these organs are treated.

Although these serious concurrent or sequential complications may occur with radiation treatment, fortunately they are largely avoidable. Resolution will occur with careful medical and nursing attention. Meanwhile the lethal effects on malignant cells will have accomplished the useful purpose intended.

Use of radio isotopes

The science of nuclear medicine has made rapid strides since radioactive isotopes became readily available in the early 1950's. Radio isotopes are chemical elements that have become radioactive through bombardment in an atomic reactor yet retain their normal chemical properties. It is possible to administer them in minute amounts to patients and to trace their course or metabolism in the body by sensitive detection apparatus (modified Geiger counters). By these means, complicated studies of the physiology of such systems as the hemopoietic, digestive, circulatory, renal, etc. are possible with ease and reliability.

Undoubtedly, radioactive iodine (I^{131}) has proved to be one of the most useful of these substances. It permits accurate assessment of thyroid function in health and disease. Furthermore, by means of special apparatus, "scanning" of the thyroid gland is possible and a "picture" of its activity produced. This aids the surgeon in determining management and the exact site that requires attention. Most malignant tumors of the thyroid gland, unfortunately, do not metabolize iodine, but the usefulness of I^{131} in treatment doses is not limited only to those few which do. All cases may, in fact, be given I^{131} treatment to ablate remaining healthy thyroid tissue. This sometimes stimulates the residual or metastatic malignant thyroid tissue to become functional and hence more vulnerable to a second dose of I^{131}.

Radioactive phosphorus (P32) is acknowledged as the drug of choice in the management of polycythemia rubra vera. Radioactive gold (Au 198) has a useful place in the control of malignant effusions into the pleural or peritoneal spaces. Besides these isotopes, others are useful in scanning the brain, liver and kidney for tumors or other defects. The possibilities of usefulness for diagnosis and research into physiology are almost limitless.

Reduction of radiation hazards

In addition to the nursing care required for the proper medical supervision of radiation reactions and their manifold manifestations, the nursing profession is called upon to have a clear comprehension of the hazards of unnecessary exposure to radiation, and the methods of eliminating this or reducing it to a minimum.[4]

Two such risks are recognized: to the individual, and the genetic risk. Repeated exposure over a prolonged period of years may cause leukemia, damage to the skin and certain other organs. We are all desirous of protecting ourselves and our patients from these risks. Similarly, gonadal damage from such radiation might cause significant harmful gene mutation so that future generations, in several hundred years, might suffer deformity or other disability. It is a matter of moral concern that the burden imposed on future generations by our possible carelessness with radiation should be kept as small as possible.

By observing the precautions described below, the nursing profession and other responsible personnel are able to keep radiation risks to a negligible level.

In a general hospital hazards may occur in the use of radium or similar sources, and radioactive isotopes. The trained medical, nursing, and technical personnel who handle these substances regularly are fully aware of all necessary precautions. They see to it that regulations are strictly observed. Patients under treatment must be identified by a card on the bed stating that a radioactive source is in use. Regular bedside nursing care and special procedures must be carried out with the utmost dispatch, so that the time spent in close proximity to the patient is minimized.

Excreta from patients receiving radio isotopes are handled with gloves and either promptly stored in suitable containers provided by the Radio Isotope Laboratory or disposed of as directed. Utensils are thoroughly rinsed in running water unless otherwise directed. Hands must be meticulously washed after nursing care is concluded.

Accidental spillage of radioactive excreta or soiling of linen by vomiting and fecal or urinary incontinence must be reported to the Radiation Safety Officer at the Radio Isotope Laboratory. Immediate steps are taken to remove the radioactive materials and to restore normalcy. These, and other precautionary safety measures, require the intelligent cooperation of nursing personnel to ensure ultimate safety for themselves and others.

Treatment by Chemotherapy

Control of malignant disease by hormones.

History: Scientific interest in the relationship between the gonads and carcinoma of the breast and the prostate gland has been long-standing. The basis of this interest was, of course, the unique stimulus-response relation, causing proliferation of tissue in the secondary sex organs. The earliest attempt to counteract this proliferation of cells in carcinoma of the breast occurred in 1896. Sir George Beatson of Glasgow,[5] treated a young woman with hopelessly disseminated cancer of the breast by oophorectomy, thus removing the gonadal source of estrogen. Almost at once she improved, regained normal strength and pursued a normal life for 8-9 months before she died.

By 1916, Leo Robb had experimentally prevented cancer of the breast in susceptible animals by oophorectomy. Furthermore, by transplanting ovaries to susceptible strains of male mice, cancer of the breast had been produced. When purified female sex hormone first became available in 1930 Lacassagne used it to produce experimental cancer of the breast in animals. Thus, significant relationships were proven in animals.

Charles Huggins of Chicago, in 1939, found that carcinoma of the prostate gland was benefited by castration.[6] Later, he used the female sex hormone alone with generally better results. Since 1950, following studies of Nesbitt of Ann Arbor and others, most cases of prostatic carcinoma are treated by both castration and the administration of estrogens.

In 1947, The Therapeutic Trials Committee of the Council of Pharmacy and Chemistry of the American Medical Association initiated a large scale clinical study of hormonal management of disseminated carcinoma of the breast. Sixty investigators in different centres over the American continent made detailed reports on nearly a thousand cases. Reports as late as 1960, indicated that androgens (male sex hormone) in the premenopausal patient, prolonged objective regression in 20 per cent of cases. Estrogens (used largely after the fifth postmenopausal year) induced regression in 36 per cent. After the eighth postmenopausal year, both hormones were more effective; estrogen produced regressions in 38 per cent and androgens in 27 per cent.[7]

More recently it has been established by Ralston Paterson of Manchester,[8] that ra-

diation sterilization of menopausal and premenopausal women enhanced survival to a significant degree. The prophylactic application of surgical oophorectomy is currently under study to determine whether additional advantages may be claimed for this procedure.[9]

When medical hormone management fails, endocrine ablative procedures such as adrenalectomy or hypophysectomy have been advocated.[9] In suitable cases these procedures are effective in palliating symptoms and still further prolonging survival.

Hormones in disseminated Ca of the breast.

In the premenopausal or menopausal woman with dissemination of cancer of the breast throughout one or more systems (i.e. with cutaneous, skeletal, or visceral metastases) it is assumed that natural estrogens will exercise a stimulatory effect, if the tumor is hormone-sensitive. Therefore, the drug of choice to oppose such an effect should be the opposite hormone, i.e. an androgen, or male hormone. Intramuscular injection of testosterone proprionate (or Depo-testosterone) 150 mg. per week for 10 weeks constitutes a single course of hormonal treatment. Subsequently or concurrently, ovarian ablation procedures (i.e. surgical or radiation sterilization) may be used to supplement, reinforce, or prolong the effective control. Later, repeated courses of injections or maintenance therapy with oral androgen (Halotestin, etc.) may be found necessary. The unfortunate side effects of such drugs are masculinization, with hirsuties, acne, deep voice, excessive perspiration and body odor, increased libido, and the chemical disturbance of hypercalcemia (increased blood levels of calcium).

In the postmenopausal woman with such dissemination, estrogens are chosen. Stilbestrol mgm. 5 thrice daily by mouth or equivalent or even higher dosage by injection is used. Other similar drugs in equivalent dosage may be used if intolerance develops or side effects are overly distressing. Dosage may be continued indefinitely if response occurs. The side effects are less troublesome than with masculinizing drugs. Initial nausea and vomiting may occur during the first week and then usually disappear. Then congestion and edema with nipple and areolar pigmentation of remaining breast tissue develops. Biochemically, sodium ion is retained and hydremia may result, leading to edema in one third of cases. These features impose a burden on the cardiovascular system and congestive failure may follow. Hypercalcemia occurs less commonly than with androgens however.

Beneficial subjective effects in 40-50 per cent of hormone-treated patients are: pain relief, improved appetite and sense of well-being. Objective results are: a gain in weight and reduction in anemia. Objective regression of soft tissue metastases occurs in 25 per cent of patients using androgens and 50 per cent using estrogens. Skeletal deposits will recalcify in 15-20 per cent using androgens and 20 per cent using estrogens. The mean survival for all cases in this category is eight-nine months but those who respond live twice as long.[7]

When ultimate failure of hormone control occurs, then adrenal suppression by the use of steroid hormones such as cortisone or prednisone may permit further control of tumor activity and proliferation. As mentioned above, still further palliation is possible in suitable cases by adrenalectomy or hypophysectomy.

Hormones in Ca of the prostate gland.

A combination of castration and the use of an estrogen drug such as Stilbestrol mgm. 5 daily, produces satisfactory control of this disease in most patients. Some patients can tolerate other varieties of estrogen drug better. Some require intramuscular or intravenous medication in high dosage for control.

The unfortunate side effects are feminization, with breast enlargement and sensitivity, nipple and areolar pigmentation, high-pitched voice, feminine skin and appearances, loss of libido. Biochemical changes with sodium ion retention, fluid accumulation and cardiac failure are possible risks. Beneficial subjective effects which may transpire are: an increased sense of well-being, improved appetite and gain in weight with loss of pain (sometimes dramatic), growth restraint and shrinkage of the prostate gland. Osteolytic

skeletal metastases (somewhat uncommon in carcinoma of the prostate gland) may recalcify. Some 50 per cent of patients experience improvement to some degree and about 40 per cent of cases now survive five years.

Endocrine ablative procedures, i.e. adrenalectomy and hypophysectomy, have been used in this disease after failure of hormone control, but with less success than with carcinoma of the breast.

Control of malignant disease by Chemical Agents.

History: The search for drugs that might control cancer has proceeded through many centuries. The use of arsenic to treat chronic leukemia has been known since 1865 (Lissauer) but, of course, it is very toxic. In 1859, mustard gas was discovered in England and Germany and was found to be a skin and nerve poison. In 1931, Frank Adair of New York used it by direct injection into tumors in animals and regression was found to occur. By 1942, Wilkinson and Fletcher in England and Jacobson in the United States were using a derivative of mustard gas called "nitrogen mustard" in human cancer, especially Hodgkin's disease, with successful regressions. In 1946, Haddow and Edith Paterson in England used urethane in chronic leukemia, myeloma, etc. From 1948 to 1959 other similar agents such as Thio-Tepa, Chlorambucil, Procytox were discovered and introduced as treatment of lymphomas and some carcinomas.

In 1948, Farber of Boston found that a folic acid antagonist called Aminopterin produced remissions in acute leukemia. Similarly, Pearson in 1949-50 discovered that adrenal steroids remitted leukemia and some breast carcinoma. In 1953, another agent, 6-Mercaptopurine or Purinethol, was found useful against acute leukemia in children (Burchenal). Investigation of antibiotics led, in 1954, to the discovery that the actinomycins were affective in the treatment of Wilms' tumor in children. In 1957, Heidelberger found fluorinated pyrimidines promising and later 5-Fluorouracil (5 F.U.) was studied by Curreri and Ansfield of Madison, Wisconsin. They reported success in some forms of carcinoma hitherto resistant to chemical treatment. In Canada, Vincaleukoblastine (V.L.B.) achieved some recognition in 1960[10] as a plant derivative that accomplished successful regression of resistant Hodgkin's disease, choriocarcinoma and hormone-resistant breast carcinoma in some instances. Its toxicity is great and benefits somewhat limited.

The search continues. Each year around 40,000 drugs of some promise are critically evaluated in the laboratories of this continent. From them perhaps half a dozen emerge with useful potentialities and are then given clinical trial and assessment.[11]

Use of Antimitotic (Radiomimetic) Agents.

These drugs, also known as alkylating agents, act within the nucleus of the cell to alter the desoxyribonucleic acid (D.N.A. molecule) so that cell mitosis is no longer possible. This effect is similar to that produced by ionization from radiation, hence the term radiomimetic.

Nitrogen mustards are useful in such diseases as the lymphomas, some chronic leukemias, myeloma and carcinoma of the lung. The side effects, apparent within the first two hours of use, are nausea and vomiting. Later, a leucopenia occurs and alopecia may follow repeated courses.

Myleran (Busulfan), a similar agent, is used for control of chronic myeloid leukemia. Usually remission occurs after three-six weeks of treatment and may persist for months. Repeated courses may be helpful in subsequent reactivity of the disease. A useful drug in the treatment of lymphomas and chronic lymphatic leukemia is Chlorambucil. Side effects may be nausea and vomiting but remissions occur in two-three weeks of treatment.

Intravenous drugs that have proven useful in some carcinomas are Thio-Tepa and Procytox. Both depress the bone marrow seriously yet prove effective in some cases of ovarian, pulmonary and gastrointestinal carcinoma.

Two other drugs in this group require mention. Urethane has been used in myeloma and chronic leukemia; Colcimid, a derivative of colchicine, may prove useful, on occasion, in the acute crisis of chronic leukemia.

Use of Antimetabolic Agents.

This second large group of chemotherapeutic agents, as their name implies, act by "posing" as an essential substrate or enzyme. They are substi-

tuted in the biosynthesis of nucleic acid and other essential amino acids but because they are not genuine "building blocks," the products formed are deficient and useless to the cell; consequently it is "starved" and dies.

The folic acid antagonists, Aminopterin and Amethopterin (Methotrexate), are functionless in the production of purines, pyrimidines and amino acids. They are useful in acute leukemias of childhood and will often produce dramatic remissions of these diseases. Methotrexate is also used with success in the treatment of some cases of choriocarcinoma. The purine antagonist, 6-Mercaptopurine, substitutes in the formation of D.N.A. This drug, too, is useful in acute leukemia but is somewhat more toxic. The pyrimidine antagonist, 5-Fluorouracil[12], has evoked interest because of its effectiveness in producing growth restraint in carcinoma of the gastrointestinal tract, ovary and breast.

The toxic side effects of all of these drugs may be severe. Marked depression of the cellular elements of the bone marrow; ulcerative stomatitis and gastroenteritis; cutaneous disturbances; hair loss; ridging of the nails are among the results of toxicity.

Stimultaneous or Sequential Use of Two or More Agents.

Warren H. Cole of Chicago was the first to use nitrogen mustard as an adjuvant treatment in the surgical management of cancer. He speculated that this drug, if used locally and systemically during surgery, might significantly reduce the dissemination of tumor cells and emboli caused by surgical manipulation. Others have used surgical techniques to expose and isolate an organ or limb so that a higher than usual concentration of alkylating drugs might be circulated or "perfused" through the affected site.[13]

The use of a high concentration of oxygen administered simultaneously with radiation therapy was thought to increase the effectiveness of such treatment,[14] but more use has been made of alkylating agents in a similar capacity. The former interferes with the resting phase of mitosis whereas the latter directly affects the activity dividing cells. It is probable, however, that instead of sensitizing the cells to radiation as hoped, the combination simply reduces the normal tissue tolerance to radiation or the chemical agent.

A recent combination of apparent promise is Actinomycin D, an antibiotic derivative, and radiation treatment in Wilm's tumor of children. A rapid response may occur and remissions appear to be of longer duration.

When one drug fails through host resistance or increased tolerance, then other drugs may be administered with some hope of further benefit. However the response is usually less successful and of shorter duration. This has led to the simultaneous exhibition of several drugs or the alternation of drugs in succession.

One example of the simultaneous use of an alkylating agent (Chlorambucil), a folic acid antagonist (Amethopterin), and an antibiotic derivative (Actinomycin D) is in the treatment of advanced cases of choriocarcinoma. Such extreme measures, however, do not offer much expectation of success. They may point the way to knowledge and methodology that eventually will offer more favorable results.

Conclusion

Throughout the extended hospital care of patients with malignant conditions, skilful nursing attention performed by personnel aware of the complexities and expectations of the various forms of treatment, undoubtedly plays a vital role in the comfort and, perhaps, the ultimate recovery of the patients.

Undoubtedly, the future holds even greater developments in chemotherapy, immunology, biology and radiation techniques. The conventional roles of surgery and radiotherapy, now sharing centre stage in the management of cancer, may soon give place to the upsurge of these other sciences. Nevertheless, the application of any such advancements will always require personal services of the highest quality. The nursing profession, among others, must and will rise to meet these challenging necessities.

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RADIATION PROTECTION IN DIAGNOSTIC RADIOLOGY

P. A. MACDONALD, M.D.

The amount of radiation absorbed by the patient and the operating personnel must be measured and controlled. In a properly disciplined radiation centre, this objective is achieved and maintained.

Some twenty-five years ago, the world of physics was populated almost entirely by physicists and their mathematical collaborators; sometimes chemists dropped in, wandered around, and tiptoed out again with things concealed under their foreheads. It was an academic world.

The explosive release of nuclear energy has changed all this. Now, the milkman argues with the baker about disrupted atoms, fallout, and radiation. Their high school sons are not only familiar with radio, infrared, visible and X-ray waves, as well as waves from radioactive substances, but they also know that they are all of the same type. The majority probably could, and certainly would if they could, tell you that radio waves are measured in metres, and X-rays in millionths of a metre.

Detection and Measurement of X-rays

What is perhaps not such general

knowledge is the fact that all these waves have the common property of being able to drive that ubiquitous particle, the electron. When driven along a wire the electron gives rise to an electrical current; when spinning about the interior of the atom the electron determines its chemical properties. Driving electrons along a wire is about the limit of the capabilities of a radio wave. X-rays and radium waves are considerably more energetic. They can and do knock electrons out of atoms at every opportunity and with the greatest facility. The electrical current produced in a wire by a radio wave can be amplified by a radio tube and eventually be made to cause sound and light waves — hence symphonies in the home, and the urge to buy Dove (25% cold cream).

X-rays, on the other hand, cannot be detected in this manner. Their presence is revealed by the effects resulting from the release of electrons within the atom. If the atoms happen to be in a gaseous state, the liberated electrons can be collected, measured, and the intensity of the liberating X-rays deduced. It is by this means that the standard of X-ray intensity is defined and measured. This is one of the main activities of those doctors of physics who wander about in hospitals with slide rules sticking out of their pockets.

If the electrons are released from atoms in a solid substance, two main phenomena may occur:

The electrons may fall back into the atoms and liberate light in the process;

or

The chemical nature of the atom may be changed.

Diagnostic X-rays

Both these phenomena are capitalized upon to utilize X-rays as a medical diagnostic aid.

If an X-ray tube be placed on one side of the patient and an X-ray film on the other, the chemical changes brought about in the film by the X-rays passing through the patient will cause the film to darken. The X-rays absorbed by the patient will not reach the film and these areas, accordingly, will remain unchanged. The relative degree of shadow on the film is determined by the relative amount of X-rays passing through and being absorbed by the patient.

The second diagnostic procedure utilizes the phenomenon of the emission of light which occurs with some classes of chemical compounds. Such compounds are mixed in an emulsion, spread on a glass screen, and substituted for the X-ray film. The screen liberates light in proportion to the amount of radiation striking it, or, conversely, is darkened in proportion to the amount of radiation remaining in the patient. Thus the fluorescent screen tells the same story as the film.

The following fact emerges as fundamental to diagnosis by the use of X-rays: *The very act of performing X-ray diagnosis involves the absorption of some X-radiation by the patient.*

Chemical and Biological Effects of X-rays

While the synthesized compounds employed in films or in fluorescent screens are altered by the incidence of radiation, this is also true with many other classes of chemicals. Since, in the ultimate analysis, the living body consists of biological cells — cells that are, in their ultimate analysis, chemical structures — and since these structures in their ultimate analysis determine the chemistry of the body, it is to be anticipated, and it has been found, that the cells and the chemistry of the body can be altered by the absorption of X-radiation. There are two main effects:

1. The chemistry of the body may be disturbed to the extent that the individual suffers some adverse somatic effect;

2. Mutations may occur. Since it is the nature of cells to reproduce their kind, the offspring of the cell may be permanently altered by an alteration in the chemical structure of a part of the parent cell. Mighty oaks from little acorns grow. Alter the acorn — alter the oak — alter the forest — alter the watershed — alter the country.

Radiation, Mutations and Evolution

Our environment is permeated with short wave radiations. These originate in naturally occurring radioactivity in the earth and from physical reactions in what was once unpopulated outer

space. The intensity of these radiations varies from point to point over the surface of the earth as does the amount of radiation absorbed by the animal kingdom scattered over its surface. This background radiation is susceptible to precise measurement and the quantities are known with exactitude.

In the early days of biology, man searched diligently but without success for the origin of mutations. They occurred, but why? Toward the end of the last century and in the early part of the present century, expanded knowledge from radiation physics became available to biologists who immediately recognized the absorption of radiation as a certain cause in the production of mutations.

This knowledge today serves as a foundation upon which biologists effectively expand their science. Indeed, having grasped the fact that mutations can be brought about by the absorption of radiation, investigators, particularly in the botanical field, are able to use this knowledge as a means of deliberately provoking them. Canada, whose economy is so intimately linked with agriculture and who maintains agricultural research stations of renown, carries out an active radiation program for producing new strains of wheat and other cereals having ever more desirable properties, both in respect to resistance to disease, maturing time, quality, quantity of yield, etc.

Quantities of Radiation Involved

The quantity of radiation required to produce genetic and somatic effects is now clearly defined; indeed the subject may be classified as quantitative. The somatic effects, relative to the genetic, require much larger quantities of radiation.

The unit of measurement of radiation is called the roentgen. It is denoted by a small *r* and named after Professor Roentgen who, in 1895, discovered X-rays. Just why the roentgen should be spelled with a small *r* and denoted by a small *r* evades the present writer. We have Ohms, Watts, and Curies, but it remains for Roentgen to be immortalized in lower case. Irrespective of the justice or injustice of this fact, the *r* still remains the unit of X-ray intensity.

The quantity of radiation required to produce somatic effects is, unfortunately, all too readily available from histories of accidental overexposure; it is also available from the intensive study given to the subject by those engaged in radiation therapy. The most emphatic of all the somatic doses will be the one that kills, and this requires about 400 or 500 *r* delivered to the whole body. Genetic effects, on the other hand, can occur from very small doses delivered to the gonads; the *mr* or 1/1000th of an *r* is usually used as the unit for measurements in this region.

There is a host of data directly provided by nature for a study of the genetic effects. The average background radiation over the surface of the earth is about 100 *mr* per year. This is cumulative over the life span of the individual, and indeed of his forbears right back to the beginning of biological time. In certain areas the background is very much higher. For example, in one city of some 5,000 population in Brazil, the average background is in excess of 2,000 *mr* per year. There are some areas not permanently populated that yield a figure in excess of 20,000 *mr* per year.

Nature provides a well-equipped laboratory for genetic studies.

Positive and Negative Effects

The phenomena associated with the absorption of X-radiation have, then, like most other things, a good and a bad side. They provide us with an irreplaceable method of medical diagnosis, with new biological products, and with a great deal of biological theory. On the negative side, the radiation is not self-evident and we can all unknowingly be subjected to radiation fields which can produce disease and upset the genetic patterns of our population.

Radiation Control

In developing a system for radiation control for diagnostic radiology we have the following facts:

1. Inherent in the procedure of carrying out diagnosis is the absorption of radiation by the patient.

2. Radiation is not self-evident; it can be neither heard nor smelt, seen nor felt.

Moreover, the effects do not occur immediately upon irradiation. There is a time lag between irradiation and the appearance of adverse effects that might result from it.

3. The biological effects are cumulative throughout the life span of the individual. An amount that could be considered negligible if absorbed only once becomes highly significant if the absorption is repetitive over a period of time. This is a condition that could occur with personnel working with X-ray equipment.

There are, then, two main areas of protection which need to be assessed:

1. The amount of radiation absorbed by the operating personnel;

2. The amount of radiation absorbed by the patient.

The latter is the much larger of the two, since the patient is deliberately irradiated.

Patient protection is achieved by evaluating diagnostic procedures both in respect to their diagnostic value and to the amount of radiation absorbed. Diagnostic procedures which involve the absorption of large quantities of radiation and are of little significance from the diagnostic point of view are today strictly avoided. Procedures are limited to those involving the absorption of small quantities of radiation and which are highly productive diagnostically. The credo of the modern radiologist is to obtain *the maximum amount of diagnostic information with the minimum quantity of radiation delivered to the patient.*

To meet this need, modern policy requires that all X-ray diagnostic equipment be subjected to quantitative physical measurement, that the dose for each procedure be determined, and that cumulative records be kept of the dose delivered to the patient.

The protection of operating personnel is a relatively straightforward procedure. Control rests on precise physical measurement. Every X-ray installation is, or should be, quantitatively surveyed; all operating personnel should continuously wear films sensitive to X-radiation. These films are changed every two weeks, developed, and measured for X-ray absorption. The cumulative dosage on every operator is watched carefully.

At present it is accepted that a professional radiation worker could be subjected to 5 *r* a year as the upper limit. In practice this figure is never approached, except in the case of an accident. If an operator's film badge shows only 1% of this amount in a two-week period, he is up on the carpet, the linoleum, or the concrete — depending upon the financial resources of the institution — and is instructed to sin never more. In a properly disciplined radiation centre, operating personnel can and do go for years without any recorded dose whatsoever.

Summary

With the aid of proper physical control, i.e., physical measurements, and through restriction of the use of X-ray equipment to properly trained personnel, there is today no danger of adverse effects occurring either to patients or to operators.

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LEUKEMIA

GAETAN BARIBEAU, M.D., C.S.P.Q.

Entire books have been written on the subject of leukemia. Each month's publications present the results of further research. Our age has conquered space: will it also achieve victory over cancer?

Blood-forming tissue is subject to the same embryologic, physiologic, and enzymatic rules as any other body tissue. Pathologically, except in a few instances, it exhibits the same disorders as well. Leukemia, for example, is one of the vast group of neoplasms. Etiologically, the same basic assumptions including the possible viral origin of cancer, are applicable to discussion and research. For some time enzymatic activity in neoplastic cells has been under intensive study but, unfortunately, the solution to the problem continues to elude science.

All blood cells originate from the same parent or stem cells — mesenchymal or reticulum cells. In the beginning, the embryo is composed of three cellular layers: ectoderm, mesoderm, endoderm. The first and third layers along with part of the second ultimately form the epithelial tissues of the body. Another portion of the mesoderm gives rise to the connective tissue while the remainder eventually makes up the variegated cells of the reticuloendothelial system.

Through the process of differentiation, the primitive cell supplies the body's need for the various varieties of cells such as fibroblasts, osteoblasts, normoblasts, lymphocytes, myeloblasts, megakaroblasts or histiocytes. Maturation results in the assumption of adult function by the differentiated cells such as is found in erythrocytes, lymphocytes, multinuclear cells, platelets and monocytes.

The reticuloendothelial system is composed of reticular cells widely scattered throughout the whole body but largely concentrated in the bone marrow, liver, spleen and lymph nodes. During embryonic life, the liver, spleen and lymph nodes attend to blood-forming requirements while the bone marrow assumes the responsibility at birth. The former then become possible extramedullary sites of hemopoiesis if a compensatory function is required or if a developmental disorder arises.

This review of embryology and physiology is requisite to an accurate understanding of the true concept of neoplasms of the blood — the leukemias. Briefly, there is a single neoplastic phenomenon that exhibits itself in different forms according to the stage or level of maturation or differentiation attained by the cell strain before it is affected by the neoplastic stimulus. If, for example, a non-differentiated cell such as a myeloblast receives the stimulus, acute myeloid leukemia is the result. On the other hand, the chronic lymphocytic type ensues when this particular cellular band is affected by the stimulus at the height of maturation.

The stimulus that initiates the developmental confusion is capable of affecting one or more cellular components of the blood at different stages and times. Scientific observations support this view. Consequently it is not unusual to find that a patient suffering from polycythemia eventually develops chronic myeloid leukemia, goes on to exhibit signs of agnogenic myeloid metaplasia of the spleen, and finally succumbs from acute myeloid leukemia. Similarly one almost invariably encoun-

ters some sign of disorder in myelocytic and megakarocytic strains in conjunction with Di Guglielmo's disease — erythrocytic leukemia.

Using this data as a basis, it is possible to make a valid morphological division of the various leukemias.

The first group, under the heading of reticuloendotheliosis, comprises lymphoid, myeloid, erythrocytic or monocytic types according to the pattern of differentiation followed by the neoplastic stem cells. Thus monocytic reticuloendotheliosis is Schilling's disease; erythrocytic reticuloendotheliosis is Di Guglielmo's disease.

The second category is made up of the acute forms: acute myeloid and acute lymphoid leukemia.

The third group encompasses the chronic varieties.

The signs and symptoms of the leukemias are extremely variable and a complete description of them is beyond the scope of this presentation.

The onset of leukemia may resemble that of aplastic anemia and, if morphological examination is inadequately performed, several months may elapse before the diagnosis is established. In such cases, the presence of aleukemic leukemia, usually in an acute form, must be questioned. Sometimes a pronounced thrombocytopenia associated with hemorrhage or purpura gives warning of the onset or existence of neoplastic disease. In other instances, agranulocytosis with pharyngeal ulceration; stomatitis with gingivitis; ulceration or anal fissure may be the factors that result in the initial visit to the appropriate specialist.

Leukemia also produces signs of a marked general physical nature. In most instances clinical examination will reveal lymph node and hepatosplenic involvement. In short, where multipotential reticuloendothelial tissue is affected, abnormal cell proliferation is manifested by adenopathy, hepatosplenomegaly or scattered swellings.

Hematological findings vary according to whether or not the leukemia is in an acute or chronic form. Acute leukemia is customarily characterized by large numbers of immature cells with very fine chromatin and a distinct nucleole possessing the properties of the specific cell strain involved. The presence of Auer rods, for example, confirms a diagnosis of acute myeloid leukemia. Auer rods are tiny, eosinophilic structures found in the cytoplasm of myeloblasts. They are the result of improper synthesis of nucleic acids.

Mature cell forms in large numbers in addition to the presence of abnormal forms favor a diagnosis of chronic leukemia. Chronic *lymphoid* leukemia is distinguished by its cellular uniformity; chronic *myeloid* leukemia by the large number of cells and their shift to the left with anomaly of maturation. Morphological blood signs are numerous and, in general, can be distinguished visually by an experienced observer. Sometimes, however, such as in cases of aleukemic leukemia or aplastic anemia, study of the bone marrow is necessary for diagnostic purposes.

Determination of the exact type of luekemia is prerequisite to adequate treatment. If one makes an exception of the general care required in all forms, medical management is based upon a choice between blood transfusion and the use of blood derivatives, radio-therapy and chemotherapy.

Current hopes are directed specially toward chemotherapeutic agents — polyfunctional, antimetabolic and steroid.

Neoplastic cell multiplication is dependent upon strongly active synthesis of nucleic acids. The chromosomes, carriers of a multitude of genes, are composed of these acids. They govern cell multiplication and bestow specific characteristics on the various strains. Nucleic acid has a complex molecular structure since it is formed from a sugar, phosphoric acid and nitrogenous bases, purines and pyrimidines.

The polyfunctional chemotherapeutic agents act to inhibit the normal physiologic function of nucleic acids by combining with free, highly active radicals, thus making them ineffective. These agents are also referred to as cytotoxic, radiomimetic or antimitotic agents. Distinguishing between these terms has little significance here. Nitrogen mustard is typically representative of the group. Study of it has led to several derivatives such as triethylene melamine (TEM), Chlorambucil (Leukeran), Thio-Tepa, Myleran, etc.

The antimetabolic products act to inhibit

nucleic acid synthesis by interrupting the sequence of chemical reaction. The agent has a chemical structure closely approximating that of the metabolite which permits its entry into the same systems of chemical reaction as the metabolite. Once linked to the reaction, the structural dissimilarities inhibit the reaction and block the entire system.

Folic acid is an essential in the synthesis of purines and pyrimidines. It has already been noted that nucleic acid is composed of nitrogenous products, phosphoric acid and sugar. Any agent with a chemical structure similar to that of folic acid or to that of the purines or pyrimidines will act as an antimetabolite to block nucleic acid synthesis. Agents thus employed are: Amethopterin, an "antifolic"; 6-Mercaptopurine, antipurine; 5-Fluorouracil, antipyrimidine. In addition there are antiglutamic agents, actinomycins and amino acid antagonists.

The third, and final, group are the steroids. They are lymphocytolytic in action and particularly helpful in inducing remissions of disease and in diminishing hemolytic factors when they are present.

The treatment of the leukemias with chemotherapeutic agents is a tricky situation, requiring close supervision through repeated hematological and physical examinations. Both neoplastic and normal stem cells are affected by the agents. The tissues where cell multiplication occurs very rapidly are the first to be attacked — for example, the hematopoietic tissue and the gastrointestinal mucosa.

Medical science has come to grips with cancer. Research is increasing and observations are piling up at a startling pace. The solution to the problem may well be the accumulation and synthesis of all data presently available.

Glossary

adenopathy — any glandular disease, especially the swelling and enlargement of lymph nodes.

antimitotic — acting against division of the cytoplasm and nucleus.

cytotoxic — capable of injuring cells.

fibroblast — a connective tissue cell.

hepatosplenomegaly — enlargement of the liver and spleen.

histiocyte — fixed macrophage (phagocytic cell) of the loose connective tissue.

lymphocytolytic — capable of dissolution of lymphocytes.

megakarocyte — a giant cell of the bone marrow containing a large, lobulated nucleus; mother cell of blood platelets.

metaplasia — transformation of one tissue into another.

myelocyte — a marrow cell containing characteristic granules and a large mononuclear type nucleus.

normoblast — a nucleated red blood cell.

osteoblast — any one of the cells of mesenchymal origin concerned in the formation of bony tissue.

polycythemia — a condition characterized by an increase in the number of red blood cells.

recticuloendotheliosis — condition of hyperplasia (increase in number of cells) of the reticuloendothelial system.

radical — a group of atoms that act as a unit, but is incapable of existence in the free state.

radiomimetic — an effect similar to the ionization of radiation.

thrombocytopenia — decrease below normal in the number of blood platelets.

. . . There are real, statistical data linking the increase in lung cancer to the increase in heavy cigarette smoking . . . Canadians smoked 3.4 billion cigarettes in 1960. By 1961, the figure was increased to 3.6 billion. In 1931, lung cancer caused 3% of all cancer deaths among males. By 1960, lung cancer caused 18.8 per cent of all cancer deaths among men. Corresponding figures for women over the same period ranged from 1.4 to 3.2.

. . . Lung cancer now causes more deaths than respiratory tuberculosis among both men and women . . . In 1960, tuberculosis caused the death of 501 Canadian men. There were 2,223 deaths from cancer. Among women, deaths from respiratory tuberculosis numbered 224 and from lung cancer, 321.

— *Health Newsletter*, Saskatchewan Department of Public Health

Nursing Care in Leukemia

DAWN WILLSON

In caring for a patient with leukemia, the nurse is called upon to use every available nursing skill.

Leukemia is a fatal disease, considered to be neoplastic in nature, arising primarily in the blood-forming organs. It is characterized by abnormal proliferation of the white blood cells and their precursors, with infiltration into various tissues of the body, principally bone marrow, spleen, and lymph nodes.

Nursing Responsibilities

Rest

The patient is usually ambulatory until fever, weakness, hemorrhage, or severe anemia become marked. Rest periods should be planned even while the patient is up. Fatigue should be avoided and the patient taught to live within his limitations. Chronic fatigue adds to discouragement and influences the patient's emotional reaction to his symptoms. It may also predispose to accidents. Frequent, short rest periods, lying flat without a pillow, will help to prevent this. Fatigue may be lessened by specific medications and transfusions. It may also lessen with better nutrition — a fact that should be stressed when giving health teaching to the patient.

Mouth Care

Scrupulous oral hygiene is necessary. The patient's mouth is usually too tender for even a soft toothbrush. Mouthwashes designed to combat unpleasant taste should be used, e.g. half strength hydrogen peroxide; if this is too harsh, an alkaline mouthwash made by the addition of a teaspoon of sodium bicarbonate to a glass of water can be used. Swollen and inflamed gums may be treated by the application of mineral oil. Patients with bleeding and sore gums are often reluctant to have mouth care because it may start fresh bleeding. Carbonated beverages are sometimes a pleasant means of softening crusts of blood and exudate.

Diet

The diet should be high in protein, minerals and vitamins. If there is gastrointestinal bleeding, or if the mucous membrane of the mouth is irritated, foods containing roughage should be avoided. Highly spiced foods are not given since they may cause irritation. Seeing that the patient eats a balanced diet is a real challenge to the nurse. The patient may be too tired or too discouraged to be interested in food. He may have anorexia or nausea associated with the constant presence of blood in the mouth. Companionship during meals, small attractive servings of food that he likes, and mouth care before meals often help to improve his appetite.

Drug Therapy, X-ray Therapy, and Transfusions

Many of the drugs used in the treatment of leukemia cause epigastric distress and nausea. Care should be taken to keep the patient as comfortable as possible, and to note any toxic reactions.

X-ray therapy is used in some cases of leukemia. When a patient is receiving this therapy, care should be taken to avoid irritation of his skin; no alcohol should be used. X-ray therapy may also cause loss of appetite or nausea and vomiting. In such instances

carbohydrates are increased and solid foods decreased.

Many patients receive blood transfusions, usually of fresh whole blood. Explanation of the procedure is important. Certain precautions must be observed in the administration of the blood. It should not be run too quickly or the possibility of putting the patient into heart failure arises. If it is fresh blood and run too slowly, it will lose its effect. The nurse must also watch for any signs of hemolytic reaction while the blood is being administered.

Hemorrhage

The nurse should be aware and alert for signs of bleeding from anywhere in the body. Stools should be examined at regular intervals for signs of fresh blood or for a tarry appearance, characteristic of bleeding high in the G.I. tract. Urine should be noted for evidence of blood. Bright blood in the urine is seldom missed, even by the patient, but smoky urine caused by old blood may go unnoticed. The patient must be protected from any trauma that may cause bleeding into the tissues. The ambulatory patient is cautioned to avoid bumps and similar injuries. He should not, for example, walk in the dark. If the patient is critically ill and is disoriented, his finger nails should be cut short to prevent him from scratching the skin; side rails should be used to prevent the possibility of him falling out of bed.

Infection

Control of infection is a serious problem. Anyone with a cold or any other infection should avoid contact with the patient. In some instances, when the W.B.C. is exceptionally low, the patient may be put into *reverse* isolation. Everything going into the room must be as clean as possible.

Emotional Problems

This is perhaps the most difficult and challenging reaction the patient and his nurse must face. Prognosis will necessarily be guarded in view of the spontaneous variation in the severity and course of the disease and the poorly predictable results of therapy. At present, unremitting research for more effective treatment is being actively pursued in many centres; the possibility exists that further significant advances may be made at any time. In this way, something can be done to temper the emotional shock experienced by the patient's family. Assurance must, of course, be given that everything possible will be done to preserve the patient's comfort and to provide freedom from symptoms.

Knowledge of the disease may color the patient's attitude toward treatment and may alter his effort in carrying on from day to day. Patients are individuals and each one reacts differently to knowledge of the disease. Some patients become depressed, discouraged, and resigned to invalidism; others show magnificent courage in overcoming their problems and living productively from day to day.

The nurse can help by listening to the patient when he becomes discouraged; by giving him attention and care as needed; by helping him to determine realistic goals; by discussing the need for and encouraging him to continue medical care and treatment; by maintaining a positive attitude about his progress and prognosis; and by contributing to patient and family planning so that, within his limitations, he may remain a productive and contributing member of society. Individual family members may also turn to the nurse and may be in need of much the same help as the patient.

The patient with leukemia is likely to be irritable, discouraged, and apprehensive. The nurse should accept his behavior and understand his need for the interest and attention of all those caring for him.

He who is of a calm and happy nature will hardly feel the pressure of age, but to him who is of an opposite disposition youth and age are equally a burden. — PLATO

The greatest pleasure I know is to do a good action by stealth, and to have it found out by accident.

— CHARLES LAMB

A Patient with Hodgkin's Disease

BONNIE HARTLEY

A patient with a chronic disease must learn to accept the limitations it imposes.

Mrs. James, a 44-year-old housewife, was admitted to hospital for a further course of therapy for Hodgkin's disease. Other than her pallor, she did not appear ill, although she looked much older than her stated age. She was very tiny, under five feet tall and weighed only eighty pounds. Her eyes seemed to dominate her whole face; they were relatively large and continuously darted about the room from object to object. This was a reflection of her manner as a whole; she rarely remained still but seemed, rather, to be in perpetual motion. In appearance she was almost puritanical. Her graying hair was always neatly combed into a coronet of braids; her clothing was plain and quite severe. The only jewellery she wore was her plain gold wedding band.

The patient's social, psychological and mental outlook on life seemed to be dominated by two principal factors: her family and her religion. She appeared to be rather withdrawn, not engaging readily in conversation with either fellow patients or nurses. This, however, did not seem to be something born of hospital fear or in any way connected with her illness. It seemed, rather, to be due to a combination of factors — personal shyness, background and home environment. Although quite reticent, she was always very pleasant; no matter how ill she felt she never complained or said she felt anything but "fine." Previous admissions had removed the novelty of hospitalization.

As a farmer's hard-working wife, free time was scarce. Any that she did have went to the local Free Methodist Church of which she was a member. She was secretary of the expanding Sunday School, and a member of one of the ladies' groups within the church. These seemed to be her main interests outside the home. She helped her husband about the farm, looked after a large rambling house as well as three school-age children, and did a great deal of baking, even though handicapped by the chronic fatigue which accompanies Hodgkin's disease and its resulting anemia. She had little time and energy to visit her neighbors on adjacent farms and did not take much interest in other community activities.

Mrs. James' formal education terminated with public school. Since her life revolved about her home and religion, her conversation was, for the most part, limited to these topics. From her speech, it was evident that she obeyed the third commandment and the majority of the English grammar rules. Her ability to grasp changing hospital situations and adapt herself to meet these demands, gave evidence of average intelligence. She was not interested in reading or television, nor did she do any handiwork in hospital; she preferred to sit (although never still) in a corner chair and watch the changing events of room and corridors.

Diagnosis

Until 1954, Mrs. James had been in

good health. She had had three normal pregnancies and her three children — two sons and a daughter — were all healthy. The patient's husband persuaded her to accompany him when he went to have a miniature chest X-ray during a tuberculosis public health survey. Unfortunately, the result was not the expected negative. Mrs. James was informed that she had a shadow on the left lung. She was placed in a sanatorium with a provisional diagnosis of pulmonary tuberculosis. She exhibited other symptoms which seemed to confirm this diagnosis. These included loss of energy for the previous six months, and a slight cough. Two lumps on the left side of her neck did not appear to be significant to the diagnosis of tuberculosis. These cervical lymph nodes were biopsied under a general anesthetic. The pathology report stated:

> The section reveals a lymph node in which the normal architecture is obliterated and in which are noted fibrosis, necrosis, reticulo-endothelial hyperplasia, and in some areas giant cells. Although eosinophilia is not a feature, this appears to be Hodgkin's disease.
>
> The blood picture was as follows:
> hemoglobin — 9.8 Gm.% (normal-12-16 gm.%)
> erythrocytes — 3,380,000 per cu. mm. (normal-4-5,000,000 per cu. mm.)
> leukocytes, total — 11,400 per cu. mm. (normal-5-10,000 per cu. mm.).

At this time the first course of nitrogen mustard therapy was initiated. A total of 29 mg. was given over a period of five days. Under this therapy Mrs. James' blood picture improved and her symptoms disappeared. She returned home believing that she had been cured. She was not told that she had an incurable disease.

Within six months, the previous symptoms of fatigue, cough and anorexia had reappeared. Mrs. James returned to her physician; this time he explained the disease and its prognosis to her. She became very depressed at the news and it took her some time to accept her condition. Her faith helped her to face her problems and the fact that this was a fatal disease. She returned to the hospital for a further course in nitrogen mustard therapy. After six treatments her cough had disappeared, her appetite had improved and she was less fatigued. Blood counts were once again within normal range. During this hospitalization, Mrs. James also underwent a series of ten deep X-ray therapy treatments to the anterior mediastinum and neck. It was hoped that this would diminish the size of the affected nodes in this region and improve her general physical state. Precautions were taken to prevent skin breakdown during this radiation therapy program. The area being radiated was kept dry and free of irritants such as alcohol, soap, lotions or adhesive. Her fingernails were kept short and clean at all times and she was taught how to scratch using the back of the nails; this was to avoid breaking the skin surface. An antiemetic was prescribed for Mrs. James as she had some nausea and vomiting, a frequent side effect of X-ray therapy.

Disease Process

Hodgkin's disease begins as a slow, painless, insidious enlargement of the superficial lymph nodes. It usually involves the cervical nodes first, followed by those in the axillary and inguinal regions. The disease occurs most frequently in young adults and is more prevalent among males than females. The cause is unknown. Research continues to attempt to determine whether it is an infectious disease or a malignant neoplasm. At present, evidence seems to favor the latter.

At first, the affected lymph nodes are discrete, movable, smooth and rubber-like; as the disease progresses, they become matted together into irregular nodular masses. Most of the signs and symptoms of this disease result from the pressure of the enlarging masses on vital structures.

Mrs. James had no recorded bouts of fever. This was unusual since mediastinal involvement had been confirmed by X-rays. Fever, which may be expected to occur as the disease progresses, is one of alternating afebrile periods accompanied by five to ten day bouts of pyrexia. This is known as a Pel-Ebstein fever. In later or acute stages the fever is usually high and sustained. The nurse should be alert for this sign.

Although there is no blood picture

characteristic enough to be of diagnostic aid, there is always a mild hypochromic anemia present which becomes progressively worse. This is due to depressed erythropoiesis and accelerated red cell destruction. This anemia serves to exaggerate weakness, lassitude, dyspnea and pallor which are all a part of Hodgkin's. Leukopenia may occur and then the patient is an easy victim to infection, particularly tuberculosis; it is these infections which may cause death. Therefore, the patient must be taught to avoid contact with infectious disease and to seek treatment at the first indication of infection. A differential count of the white blood cells generally shows an increase in the granulocytes and monocytes. If bone lesions occur, there may be increases in serum alkaline phosphatase and blood calcium levels. Occasionally, the eosinophils are greatly increased above the normal 1 to 3% of total white cells. A thrombocytopenia may occur and bleeding from the gums and mucous membranes results.

For nearly two years Mrs. James remained asymptomatic. During this time, hope stirred within her that the doctors were wrong — that she did not have a fatal disease since she appeared to be cured. In 1956, however, she experienced fatigue and a feeling of tightness and pressure in the left side of her chest. Each deep breath meant a sharp stabbing pain. Examination revealed the presence of new nodes — a small mass behind the left sternomastoid muscle and in the axilla. After a total of 24 milligrams of nitrogen mustard over a five day period, the patient could breathe more easily and once again could sleep with only one pillow, rather than propped up on several.

Readmission

Four years later, the choking sensation and the chest pain returned. Mrs. James was readmitted to hospital for more nitrogen mustard therapy. She had developed a pleuritic chest pain, a non-productive cough and a feeling of fullness in the throat which caused her voice to change pitch, especially when she raised her arms. She admitted she dreaded the impending treatments because she knew how miserable she would feel once they had begun. She was resigned to them, however, because the feeling of pressure in her chest and of being unable to breathe frightened her. To ensure a good night's rest the Gatch frame was raised to a high Fowler's position with pillows behind her for support and comfort. An emergency supply of oxygen was kept available on the ward should she suddenly need it. On admission, her physical examination showed that everything, excluding the lymphatic and blood systems, was normal; new nodes were enlarged, this time in the left superclavicular area, left anterior cervical area, and more in the left axilla. The diagnosis was "exacerbation of Hodgkin's disease." The chest X-ray also showed a large parasternal mass on the left side of the superior mediastinum with evidence of infiltration into the lung fields. Compared to previous films, this mass had enlarged considerably. The routine admission urinalysis was normal but this was not true for the hematology report: hemoglobin was reduced to 10.8 grams % — her old enemy, anemia, had also gained foothold during the disease remission. The sedimentation rate was elevated to 67 mm. per hour from the normal 0 to 20 mm. per hour.

Having had the disease for nearly seven years, Mrs. James had learned to face her impending death. She did not fear death but believed it to be something far in the future. Her family seemed to reflect this attitude. They treated her illness with matter-of-factness, although this was not always the case. Her three children learned of her condition in a rather tragic manner. The family doctor indiscreetly told a relative that Mrs. James would "not be here" in six months. This was repeated to this relative's children, who, in turn, repeated it to the patient's children at school. The children returned home greatly disturbed and upset. It took much careful explanation to reduce their feelings of desolation and shock.

Nursing Care

While in hospital Mrs. James had slight leukopenia. It was necessary to protect her from infection by keeping her away from direct contacts with

patients or staff members known to be potential sources of infection. She was aware of the importance of avoiding infection at home — a difficult task with three children.

Mrs. James had to have many samples of blood taken to check for toxic effects of the nitrogen mustard, (which may cause granulocytopenia or anemia). She hated and feared "needles," so it was important to ensure that sufficient blood was taken each time and that blood labels were written correctly. Blood specimens were obtained at a time that was least upsetting to her — for instance, never close to meal time.

Although she has returned home, the prognosis is poor. Hodgkin's disease is inevitably fatal. She has come to realize that fatigue is a constant companion and this limits the amount of work she can do. In its most acute stages, Hodgkin's disease may kill in about two to four weeks; in its chronic forms, a patient may live as long as twenty years. Death is usually due to pressure on the bronchi or trachea by enlarging lymph nodes, or else the patient succumbs to an infection. With each exacerbation, Mrs. James is finding it more difficult to breathe. It is feared that a subsequent attack will not respond to therapy and she will suffocate.

Mrs. James realizes the importance of frequent visits to her doctor so that he can keep a close check on her general physical condition, watch for any further involvement of the lymph nodes and observe the effect of the drugs.

Only through the consolidated effort of a number of people — the doctor, the hospital team, her family and herself, can Mrs. James be kept as comfortable as possible for the remainder of her life. Since hers is a chronic, fatal disease, her mental attitude will be greatly influenced by the people around her. It is important that she be kept happy as well as physically comfortable. Most of the responsibility will fall on Mrs. James' family. With their aid and support she will be able to face her future with courage.

I had expected to discover that nursing a patient with a chronic illness, especially one that was inevitably fatal, would be depressing. This was not the case. Mrs. James' quiet optimism often served to cheer up those of us who nursed her.

Summary

I learned much about the physical and psychological aspects of Hodgkin's disease from nursing this patient. Her illness made me realize, moreover, the importance of early diagnosis and treatment; in this way life may be prolonged for many years. The most important lesson I learned was that a strong faith held by the patient, along with support from the family can help anyone to accept the limitations and problems that a chronic disease imposes.

In The Good Old Days

(The Canadian Nurse — APRIL, 1923)

In the battle of life, just as in actual warfare, there are two great forces brought into action — offensive and defensive. *Sanitation* may be compared to the former, and *hygiene* to the latter.

In sanitation, we wage an active crusade against the germs of disease — we burn them with fire, we poison them with antiseptics, we demolish their strongholds of filth, and in every way actively pursue them to their death.

In hygiene, we strengthen our fortifications and look after the well-being and equipment of the garrison.

* * *

The death of Professor Roentgen, the discoverer of the X-rays or the unknown rays, occurred in February. He was born in March, 1845, at Lennep, near the Ruhr district. His great discovery was made at Wurtzberg in 1895. He was 78 years old at the time of his death.

PRIZE WINNERS

Each year since 1954, the Macmillan Company of Canada has been the beneficent godfather offering cash awards for the cream of the comprehensive nursing care studies written by students in the schools of nursing across Canada. Each year, a corps of able instructors and supervisors in those schools have cooperated with *The Canadian Nurse* in the evaluation of the studies.

The prizes were sent to each winner during the last week in February. For the record, and to encourage more students to compete, the following list has been prepared. For the first time there has been a tie for second place. Generously, the Company has awarded each student $15.00.

Five provinces are represented by this year's winners — from Ontario westward to the Pacific coast. Come along, students in Quebec and the Atlantic provinces. We would be happy to announce tiptop entries from you in next year's prize winning list.

First Prize of $25.00 — Sandra Young, St. Joseph's Hospital, Victoria, B.C. "Jennifer Learns about Diabetes".

Second Prizes of $15.00 — J. Gates, Saskatoon City Hospital, Saskatoon, Sask. "Cancer of the Breast".

Lois J. Ford, University of Toronto School of Nursing, Toronto, Ont. "Johnny, a Delinquent".

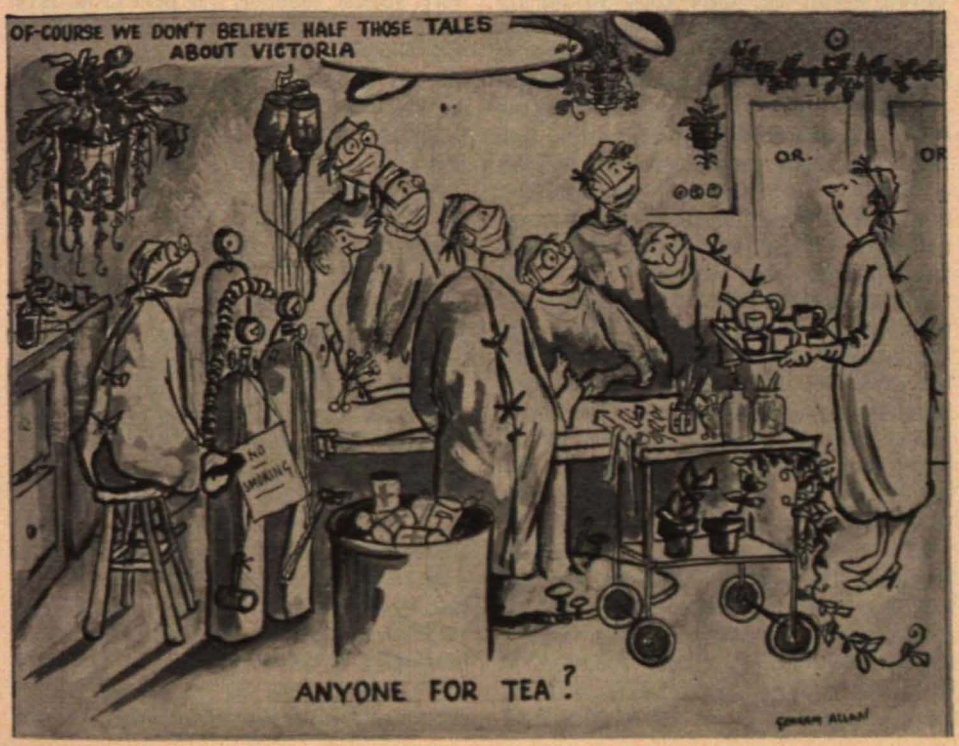
Honorable Mention (Book Prizes) (Names in alphabetical order) Bonnie Hartley, Kingston General Hospital, Kingston, Ont. "A Patient with Hodgkin's Disease".

M. Kitt, Edmonton General Hospital, Edmonton, Alta. "Fractured Ankle".

Bernice Schettle, University of Alberta Hospital, Edmonton, Alta. "Gastric Ulcer".

Diane Sangster, St. Boniface Hospital, St. Boniface, Man. "Role of the Nurse in the Care of Geriatric Patients".

The following cartoon appeared in the Western D.V.A.tions Magazine. Mary M. Worthy, at present a nurse in the Yukon Territory sent it in. We thought you would enjoy it.



THESE FOUR

LORRAINE F. MILLER

Under professional guidance and with professional assistance, family members can provide excellent nursing care for patients with long-term illnesses.

The head nurse surveyed the accumulation of work lists and orders piled on her desk, and sighed as she prepared to report to the oncoming evening staff. She glanced at the discharge list and wondered aloud, "How will these four ever manage?" Why was she so concerned about these particular patients? What was the reason for her worry? Patients come and go in all large hospitals; there had been several other discharges from her ward that day.

Four patients, all with the same diagnosis, but with little else in common. Four patients with cancer! How does the patient with a diagnosed malignancy face the return to daily living and to activity? The head nurse wondered about the care they would receive in their homes. She was very much aware that all four would require some assistance in their programs toward recovery.

She might have felt reassured had she been able to discuss her worries with her counterpart in the community. The public health nurse in many communities, urban or rural, provides continuing care and supervision for patients referred to her. More and more frequently physicians are requesting "follow-up" nursing and supervision after discharge from hospital. This may include bedside care or may be supervisory only. Programs are planned to meet the patients' needs. What happened to the four patients the head nurse was worried about?

Mr. White went home by ambulance. His prognosis was not favorable. He had had surgery for a spinal malignancy; he suffered from arthritis; had had a mild cardiovascular accident; was paraplegic and, due to incontinence, had a permanent catheter. He was fortunate in that his physician referred him to a Home Care Project. His care continued almost as in hospital, except that his family provided the "interim care" required beyond the limits of that given by the members of the Home Care team. The visiting nurse gave him a full bed bath three times weekly. The physiotherapist visited to provide passive exercise and she demonstrated exercises that could be done by the nurse. Orderly visits were arranged for a weekly change of catheter and enemata as required.

Mr. White's care was relatively routine but there were areas of special concern. A fracture board was essential equipment; a piece of heavy plywood was cut for this purpose. It was found that a sheet of foam rubber placed over his mattress equalized pressure and contributed greatly to his comfort. Special attention was paid to all pressure areas when the patient was bathed and the family members were taught to watch for any signs of skin breakdown. Whenever he felt well enough Mr. White was encouraged to be up in his wheelchair. He was able to transfer from bed to chair with little difficulty. He enjoyed watching T.V.; his neighbors visited frequently and he was happy in the program established for him.

Ultimately, however, his condition regressed until he became fully bed-ridden. At this time a hospital bed was secured. The original program was maintained but more emphasis was placed on care of the skin and positioning. Mr. White received oral analgesia as required. He had not been aware of his diagnosis when he was discharged from hospital. However, as he became weaker and had more and more discomfort he asked his physician for information about his condition. He accepted the news calmly and his knowledge of his diagnosis relieved the strain that had been developing in all those working with him. Team members and his family were finding that his questions were increasingly difficult

to answer.Perhaps one of the most difficult aspects in the care of cancer patients in the home is the strain of facing the questions the patient will ask, sooner or later, about his diagnosis if the family has requested that he should not be informed.

* * *

Miss Brown went home in the family car. She was looking forward to regaining her strength and returning to hospital for closure of her colostomy. A middle-aged, single lady, she made her home with a married sister. Other members of her family lived in the city and they were all extremely concerned about her care and well-being. They had been very positive in their insistence that she should not be made aware of the seriousness of her illness or that she had an inoperable malignancy.

A month after her discharge the family physician requested the visiting nurse to make regular calls. Miss Brown's colostomy was to be irrigated and she required assistance with bathing. The family cooperated in providing the simple equipment required. When she felt well enough, her irrigation was done in the bathroom; as she became weaker all of her care was given at the bedside. Her condition deteriorated rapidly; her skin began to break down; she suffered from nausea and soon became dehydrated.

Miss Brown's nursing care was arranged for early afternoon which allowed her to sleep in the morning so that she felt stronger. The care of her skin was most important. Frequent rubbing with a cream lotion, relief of pressure with foam rubber and, later, a fleece were used in an attempt to prevent decubiti. Corn starch patted on sparingly with a puff provided further protection. Her family was assisted in planning her diet since difficulties arose as her appetite became more and more capricious.

In this family, too, the nurse had to contend with the deep concern of the family members. They transferred their worries to her. The physician faced a similar situation. Miss Brown received devoted care from her family, supplemented by regular, professional care from the visiting nurse until her condition demanded further hospitalization.

* * *

Mrs. Black was discharged to her home in a small country town. She had had a mastectomy and cobalt therapy. There was a very small area in her incision still unhealed. She was given a small supply of sterile dressings to take home with her and she planned to contact the public health nurse in her community if she required further assistance.

Mrs. Black was keenly interested in planning for her recovery. She had inquired about a prosthesis and planned to secure a well-fitted form when her incision was healed. The physiotherapist had visited her in hospital and outlined a routine of daily exercises. Her prognosis was excellent; her condition had been detected early and she had had prompt, thorough treatment.

Mrs. Black's home care was relatively simple. Dressings would be required for a short period only; if she required more than the hospital had given her she would prepare and sterilize them in her oven. She would return to the Clinic for regular supervision and check-up. She went home to her family, happy and confident that her disease had been conquered. She realized, though, that she must always be alert for any danger signs; that her continued well-being was, in part, dependent on maintaining a state of optimum health. Though she had been extremely concerned when she first became aware of her diagnosis, she had discussed her condition with her physician. She had been reassured throughout her period of therapy and she had been able to overcome her fears and face her future optimistically.

* * *

Mrs. Green's position was an especially tragic one. Her condition had been diagnosed six months previously when abdominal surgery had merely confirmed the suspected diagnosis. Following her surgery and convalescence she had been discharged and had managed at home where her mother and teen-aged son cared for her until she had to be hospitalized for intravenous therapy to relieve nausea and acute dehydration. She had insisted on discharge again in spite of her physician's reluctance since she would require almost full bed care and frequent sedation. Her doctor made arrangements for the visiting nurse to give daily care and administer the necessary intramuscular injections as required for relief of pain. Mrs. Green had been home only a few days when the nurse realized that she was regressing very rapidly. Her sedative was inadequate and she was becoming dehydrated. Severe respiratory distress developed and she returned to hospital in very poor condition.

All of these patients received some nursing care in the home situation. Such care can be *almost* as adequate

as nursing care in hospital. The "almost" refers to the very special equipment needs of some patients. It is possible, however, to set up apparatus such as tap suctions, and to introduce even more complicated equipment. In many instances home supplies can be adapted to nursing needs. Dressings can be prepared by members of the family and sterilized in the oven. In some centres the Cancer Society may provide dressings.

As in hospital, special care of the patient's skin is an important part of home nursing care. Pressure points should be massaged carefully; the use of fleece and foam rubber will assist in preventing pressure areas, and is extremely helpful in the care of the emaciated patient. As long as the cancer patient is able to be up he is encouraged to maintain his activities of daily living. Prescribed exercises may be done by the patient himself or with the help of his family or nurse. Even if the patient is confined to bed he should be encouraged to maintain good posture. Range of motion exercises will help to keep his limbs flexible.

The patient with cancer should receive a well-balanced diet; an adequate protein intake is especially important. If patients have difficulty swallowing, the use of sieved baby foods provides a good source of nourishment. They are available in many varieties in small portions and are not wastefull. They can be diluted to use as soups and can be adapted to tube feedings, if necessary.

As more referral and Home Care programs are established in our hospitals and communities, it is reasonable to expect a marked increase in the "home care" services available to the patient. The four patients described received continuity of care to varying degrees. The aged cancer patient may frequently prefer to remain at home. As one elderly philosopher quietly observed, "I plan to die comfortably and in my own bed." Many patients can be cared for adequately in their own homes by their families when professional help and supervision are available.

Communications between the hospital and community services are still unsatisfactory. If the head nurse in the hospital was concerned about the care of her patients on discharge, her counterpart in the community also had her worries. She too, frequently has to grope her way into establishing good rapport. Often she is unable to contact the physician before she makes her initial home visit. The nurse in the community is concerned about what happened when the patient was in hospital; she wonders whether the patient or his family is aware of the diagnosis; she looks forward to the time when she will receive the referral before the patient is discharged. Advance referral would permit the head nurse to pass along necessary orders and information to the visiting nurse. The latter, in turn, can plan for a much more effective program designed to meet the patient's needs as adequately as they were in the hospital.

In any discussion on the care of the patient with cancer, emotional reactions must be considered. Though the public today is much better informed about this disease than in former years, there remain elements of uncertainty and fear. The hospital nurse has the support of others to relieve her of some of the burden. The nurse in the home is, of necessity, in much closer contact with both patient and family; they tend to look to her for reassurance and guidance. Nurses must be prepared to meet demands that require emotional and physical effort. The family priest, minister or rabbi can assist greatly in helping the family, especially when the patient reaches "terminal care"; the nurse can encourage the family to make use of his ministry. The physician and nurse can care for the physical needs of the patient but there is a need beyond this that requires special help.

The care of the cancer patient in the home demands the same nursing skills as in hospital. His needs can be met in almost all instances. However, in addition to good nursing care, we should mix into our program a little extra sympathy, a special measure of understanding and hope, a large amount of faith.

Punctuality is the courtesy of kings.

Nursing Care of the Patient with Advanced Cancer

L. RICHARDSON

The cancer patient presents a challenge to those caring for him.

It is estimated that cancer will strike one of every eight persons reaching 45 years of age by the age of 65. The significance of this to the nurse is that she will be caring for an ever-increasing number of patients with this disease. Many of these persons, if diagnosed early enough, will be cured. It is the purpose of this study, however, to discuss the nursing care of the patient who is in the terminal stages of cancer.

The objective of nursing care for a patient with advanced carcinoma is to provide a therapeutic, supportive environment wherein his psychological and physical needs will be met.

PSYCHOLOGICAL NEEDS

Any individual afflicted with cancer will experience fear and apprehension whether or not he is aware of his diagnosis. He will fear the treatment, the possible disfigurement to his person, and death; he will be concerned about the effect of his illness on his family and how it will affect the family's financial situation. Many people with cancer have feelings of guilt stemming from a misconception of cancer — as being a disgrace or a form of punishment. Frequently, the patient's true feelings remain covert. The nurse must be aware of the many fears and worries that her patient may have as a result of his disease; she must also realize the importance of her role in helping him to verbalize them. Many times the physician and social worker can be of assistance if they are informed of the patient's reactions to his illness.

Before the nurse can provide comprehensive care for her patient, she must know what he and his family have been told about the illness and its prognosis. There is no easy answer to the question, "Should the patient know the truth?" It is clear, however, that if the patient questions the nurse regarding his illness, the physician should be informed. In many instances, the patient would prefer to know the truth. The decision of whether or not to tell the patient and his family of the true nature of the illness, rests with the physician. Certainly the nurse as well as other members of the health team should be aware of how *much* information has been divulged to the patient and his family.

The patient's family is probably the first to realize that there is no hope of recovery. If the information is unexpected, it will be a great shock; individual members of the family will have to be given time to become accustomed to the idea and all that it will mean to them. Encouraging the family to verbalize their distressing emotional reactions not only brings them relief, but also encourages them to formulate plans for the future. Free and frank discussion should never be avoided. The nurse's greatest service, under these circumstances, is to be a sympathetic listener ready to encourage and direct fears and emotions into activities. She should also recognize the value of spiritual guidance for the patient and his family, and notify the priest or minister who can best meet this need.

Ambulatory status should be maintained as long as possible. A well-

"crying solitary in lonely places"

DILANTIN*

(diphenylhydantoin, Parke-Davis)

permits a richer life for the epileptic

"It has been more than twenty years since the introduction of diphenylhydantoin sodium (DILANTIN) as an anticonvulsant substance. This drug marks a milestone in the rational approach to the management of the epileptic."[1] In grand mal and psychomotor seizures, DILANTIN is a drug of choice for a variety of reasons: • effective control of seizures[1-9] • oversedation is not a common problem[2] • possesses a wide margin of safety[3] • low incidence of side effects[3] • its use is often accompanied by improved memory, intellectual performance, and emotional stability.[10] DILANTIN (diphenylhydantoin, Parke-Davis) is available in several forms, including DILANTIN Sodium Kapseals, 0.03 Gm., bottles of 100 and 500; and 0.1 Gm., bottles of 100, 500, and 1,000. Other members of the PARKE-DAVIS FAMILY OF ANTICONVULSANTS for grand mal and psychomotor seizures: PHELANTIN* Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100. for the petit mal triad: MILONTIN* Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 500; Suspension, 250 mg. per 4 cc., 16-ounce bottles. CELONTIN* Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100. ZARONTIN* Capsules (ethosuximide, Parke-Davis) 0.25 Gm., bottles of 100.*

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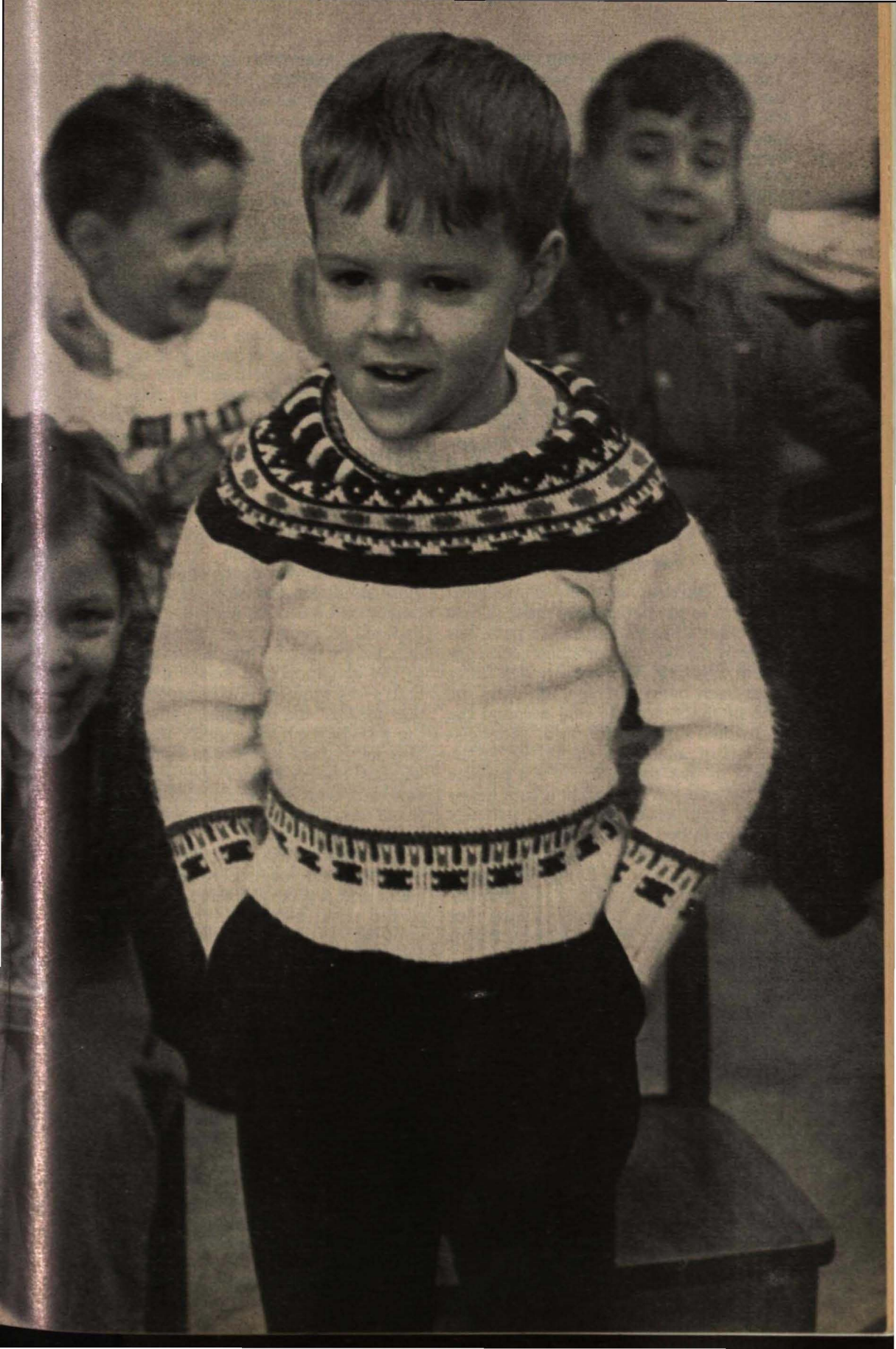

planned program of occupational therapy will help keep the patient busy in mind as well as in body. Idleness leads to boredom, irritability and depression, all of which tend to exaggerate the patient's physical discomfort and make general management more difficult. If the patient has a special talent or interest that he has never had time to develop, the problem of keeping him pleasurably occupied is easily solved. Some women find satisfaction in handiwork, especially if it is done for a member of their family. For some patients, reading, card-playing and music are the answer. It depends on the individual. Contacts with neighbors and friends should be encouraged and maintained as long as possible. When the patient becomes bedfast, he may derive satisfaction from other diversions — such as having his bed placed near a window where he can watch outside activities.

Physical Needs

The problem of pain is of great concern to the patient and nurse. There are other diseases that cause pain, but none is as likely to produce such constant suffering. The severity will differ with each patient, depending upon the site of the cancer as well as upon the individual's pain threshold. Administration of analgesics should be as ordered so that the pain will not become too severe. Various nursing care measures, such as changing the patient's position in bed, massaging, etc., help to enhance the action of the analgesic. If the nurse has a soothing, unhurried manner and if she takes a few minutes to listen to the patient express her feelings, she can help to make the pain more bearable.

Maintenance of adequate nutrition is important and difficult. Tissue disintegration often results in rapid weight loss. When the digestive organs are involved, there is interference with the digestion, assimilation and metabolism of food. The main purpose in planning a diet is to provide the patient with the foods that he needs to keep up his strength and feeling of well-being. On this basis, most physicians advocate a diet high in protein, fats, and vitamins. It is the nurse's responsibility to make sure that the patient is able to tolerate the diet prescribed; to see that he is receiving sufficient food and fluid intake. Patients whose intake per os has been reduced require special mouth care as hygienic and comfort measures.

Prevention of decubiti is an important aspect of care. Ulcers are difficult to treat and tend to aggravate the existing discomforts of the patient. Prevention is thus the goal to be achieved. Preventive measures include:

maintenance of peripheral circulation by frequent bathing and massage; toughening of the skin by frequent alcohol rubs; prevention of cracking or chafing of the skin by the application of creams and oils; reduction of skin dampness by change of linen, when necessary; prevention of pressure and skin irritation by frequent change of position and by keeping the bed sheets smooth and free from crumbs.

In spite of the best care, bedsores may develop. Constant alertness, is the best assurance against them.

An ulcerated cancer, whether it begins as direct invasion of overlying tissues or by central necrosis, becomes exposed to pyogenic organisms and is infected by them. Thus, sepsis is added to the condition and many of the patient's discomforts and symptoms are due to this and toxemia, rather than the growth itself. Obviously the infection cannot be eradicated completely without eradication of the cancer; it can, however, be diminished by conscientious nursing care as well as by antibiotic therapy.

The basic treatment of an ulcer, wherever it is located, consists of frequent and regular cleansing. Irrigations of the ulcer site should be continued until the return fluid is clear. It is only after thorough cleansing of a malignant ulcer that an antiseptic solution is of value. The pleasant odor, characteristic of many antiseptics, also produces in the patient a psychological effect of cleanliness. Each patient should be taught to do as much of this procedure as possible; this is particularly true for the patient who has cancer of the mouth, where hourly irrigations are necessary.

Offensive odors are due to the sloughing of tissues and secondary infection. Frequent irrigations of the ulcer help to reduce this odor. Charcoal

and chlorophyll dressings are sometimes ordered to minimize it. Room deodorizers are also effective. The nurse learns to accept and becomes less aware of the distressing odors; she must remember that the patient as well as his friends and relatives are more sensitive to it.

SUMMARY

Nursing care of the patient with advanced carcinoma is directed toward meeting psychological and physical needs. The nurse can help to provide the patient and his family with the support that they require. Because cancer is a long-term disease, it gives the nurse an opportunity to use the entire battery of skills that she has learned. Even though the battle for life has been lost, the nurse who has succeeded in supporting the spirit to the end should derive lasting satisfaction.

A Hospital Postpartum Teaching Program

GAYDA M. HORNICK, B.SC.N. *and* ELLA M. HOWARD, B.SC.N.

How the New Mount Sinai Hospital in Toronto eases the worries of new mothers before they take their babies home.

The need for mothers to have a planned program of instruction during their postpartum period in hospital has been recognized for many years. This has been evident from observations and comments from mothers, doctors and nurses in the community. Hospitals, too, have been aware of the need and have desired that their patients receive not only adequate care while in hospital, but that they be prepared to care for themselves and their infants when they return home.

In our hospital, as in many, the responsibility for planning and carrying out the teaching was shared by the obstetrical supervisor, head nurses and staff nurses. Several problems were apparent:

1. The sincere attempts of the supervisor and head nurse to carry out a planned program often were thwarted by the pressures of administrative problems.

2. The staff did not always feel assured that each mother had received adequate instruction.

3. Continuity between prenatal teaching, the postpartum program and the instruction available in the community at well-baby clinics or from public health nurses was not always satisfactory.

4. Every staff member did not always have adequate knowledge of the community resources.

5. The turn-over of staff, shorter periods of duty and what appeared to the patient to be a constant change of nurses added to the problem.

6. The patients, too, appeared in ever-increasing numbers and their length of stay in hospital became shortened.

In January, 1958, after careful evaluation of the situation, a full-time instructor was appointed to the obstetrical department to plan and implement a program of instruction for the mothers. This was to ensure that the mothers would feel more secure in caring for themselves and their infants at home. It was to assure also that the teaching would be in accord with that approved by the doctors and given by public health nurses and at well-baby clinics.

The instructor's second responsibility was to the postpartum and nursery nurses in orienting them to the program so that each, in her teaching, was

complementing the other in assisting the mother.

Each instructor has been selected carefully. Each has been a registered nurse particularly interested in maternal and child care. Each has had preparation in teaching and in public health nursing. It has been considered valuable for the instructor to have had community experience and preparation in public health nursing.

A room in the department is equipped as a classroom with comfortable chairs for the mothers; a bulletin board, blackboard, cupboard, desk, table and necessary equipment for bathing an infant. Though a doll is available if required, an infant is bathed during the demonstration bath. A lounge on one of the postpartum wards is used for discussion groups.

Instruction may take the form of demonstrations, discussions and individual conferences.

1. The baby bath is demonstrated by caring for an infant from the nursery. The equipment used is similar to that used in the home. Substitutes and inexpensive equipment are suggested. Each mother who has attended the demonstration bath and is a primipara has the opportunity to bathe her own baby before going home. This has proved very helpful to the young mothers. The same may be arranged for mothers who return to take home their premature infants who have remained in the nursery for a time.

2. Breast feeding is encouraged. However, formula-making is demonstrated. The mothers see the equipment and then observe the steps in the preparation of the formula as they will prepare it at home. Typed sheets with general information and procedure are given to the mothers. Due to language barriers the information has been translated into Italian and Greek.

3. Discussions or informal conferences cover such topics as breast feeding, the first day at home, the first week at home, or topics the mothers may suggest.

4. Individual teaching attempts to meet the specific needs of the individual patient, such as a safe and easier way for a mother with arthritic hands to handle and bathe her baby; bathing a baby with an anomaly such as meningocele, changing a dressing.

5. Conferences are held with nurses in the department to share information and to assist with the orientation of new staff to the program.

6. Conferences are held with doctors for purposes of securing information or when there are specific problems regarding their patients.

The hospital does not conduct a school of nursing and therefore is staffed completely by registered nurses and certified nursing assistants. Two independent schools of nursing make use of the obstetrical department for experience for their students. The students, under supervision, participate in the program as it relates to the mothers for whom they are caring. Flexibility in the program is necessary to permit the student to give complete care to the mother and her infant.

The program appears to be successful. The doctors are pleased and encourage the mothers to attend. Reports from nurses in the health field have been encouraging. Certainly, the mothers express their appreciation. Those who return a second time to hospital and attend classes are surprised at the changes that have taken place. They feel they learn new things each time.

The instructor and obstetrical staff are more satisfied as they realize that each mother has had the opportunity to participate in a planned program adjusted to her specific needs.

A miniature heart-lung machine developed by the University of Michigan pediatricians and surgeons, can boost the survival rate of infant open-heart surgery. The scaled-down apparatus permits the precise control needed for infant operations. Its capacity is about three pints of blood — an adequate amount for babies weighing up to 22 lbs. The smallest baby operated upon using this equipment weighed less than six pounds; the youngest was 12 days old. Both recovered. — *Heart Research Newsletter*

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

WHAT DO THEY DO AT CNA HEADQUARTERS?

THIS QUESTION HAS OFTEN BEEN ASKED FROM ONE COAST TO THE OTHER.

—WORLD OF NURSING—

INVITES YOU TO TAKE A LOOK INSIDE NATIONAL OFFICE.

Within the shadows of those stately buildings housing the leaders of our land stands another, housing a group of people for whom the words "never have so many owed so much to so few" could well have been written.

(Dom. Wide Photographs, Ottawa)

HEADQUARTERS

It is the top floor of this building that is known as National Office. It is here that a team of 17 women work devotedly for the CNA's 70,000 members, and indeed all Canadian nurses. Each working day they provide nursing advisory services; collect and compile for distribution data and statistics on nursing; assist nurses seeking employment abroad and those seeking employment in Canada; assist in career counselling programs; conduct studies in research; publish material on current nursing practices; manage the loan fund for nursing education and the CNA Retirement Plan; accept and channel scholarships for graduate study.

(Dom. Wide Photographs, Ottawa)

M. PEARL STIVER AND HELEN GRAY

Heading up the team is M. PEARL STIVER, a woman who has been interested and active in all fields of nursing since graduating from Toronto's Western Hospital in 1932. As Executive Director she administers the entire CNA program, a role which makes her one of the busiest executives in the country today.

The responsibilities of a CNA executive director in carrying out the decisions of the executive committee (the governing body of the CNA) are many but they constitute only one facet of an exacting job. Another is to represent the CNA in many organizations — the Canadian Council of Nutrition; the Canadian Committee on Nursing; Civil Defence Nursing Advisory Committee; and the Emergency Measures Organization. She acts in an advisory capacity to the Canadian Red

Cross Society; the Victorian Order of Nurses; St. John Ambulance; Hospital Auxiliaries; UNESCO; and the Canadian Welfare Council. The executive director also acts as a consultant to provincial associations on national nursing policies and practices and through these associations acts as consultant to provincial departments of health. On the international scene she attends the International Council of Nurses' board of directors meetings as adviser to the president, and the ICN Congress as adviser to the CNA voting delegates.

(Dom. Wide Photographs, Ottawa)

To assist her are five well-qualified nurses, a public relations secretary, and an administrative staff of ten. This is a team in the fullest sense of the word. Each works with the other toward the common goal of achieving the association's broad objectives. It is this sense of teamwork that impresses you even on a first visit to 74 Stanley Avenue.

At 8:45 each morning the beehive of activity begins. Pearl Stiver usually arrives about 9:00 (if she isn't on a plane to any of the cities across the country where her presence is required). Though no two days of her life are alike, each begins in the same way. She makes a complete round of the office to say good morning and have a chat — a practice now rare in our bustling society, but one which sparks incentive and explains the high morale of her staff.

Back at her office she consults with secretary HELEN GRAY on the day's activities. "Helen doesn't let me forget a thing," says Pearl Stiver enthusiastically. "She knows me better than I know myself at times." In this room Pearl Stiver's passion for African violets is evident, but it is the two framed

(Dom. Wide Photographs, Ottawa)

DR. MUSSALLEM, LILLIAN CAMPION AND GLENNA ROWSELL

photographs on the wall that first command your attention: one of Florence Nightingale, the other of Marion Anderson. Both reflect the one quality she believes essential in any profession — humility. It is this quality that has made Pearl Stiver an admirable leader throughout her own career.

Her leadership has been felt by no one more in CNA than Dr. HELEN MUSSALLEM, a name familiar to all who have read "Spotlight on Nursing" (report of the pilot project on the status of schools of nursing in Canada). "The success of my two-year study was due in no small part to Pearl Stiver's belief that leadership is inspiration not domination," says the director of special studies at National Office. Though Dr. Mussallem is presently seconded to the Royal Commission on Health Services, she does get into the office a few hours each day to lend support to GLENNA ROWSELL and LILLIAN CAMPION who have undertaken programs implementing two of the recommendations in her report.

The School Improvement Program leaves little time on Glenna Rowsell's hands. For the past three months she has been organizing workshops across Canada to assist schools of nursing in upgrading their educational programs. This activity will keep her away from National Office until June. When she is at home base, she (as do the other nurses) speaks to local hospital groups and arranges familiarization visits of students to the association's headquarters.

Travel also makes a demand on the third member of the special studies group, Lillian Campion. She has just returned from workshops sponsored by

the University of New Brunswick in connection with her Study on the Evaluation of Nursing Service.

These and other projects keep the typewriters going at an ever-steady pace in National Office . . . like JUSTINE DELMOTTE'S Exchange of Privileges Program. The CNA is one of 59 nations participating in this plan to provide facilities for professional experience and study for nurses outside their own countries. Her extensive experience in nursing in such countries as Germany, Austria, Switzerland, Denmark, Thailand, Cambodia, Morocco and West Africa, enables her to give expert guidance to Canadian nurses who daily seek this opportunity.

(Dom. Wide Photographs, Ottawa)

JUSTINE DELMOTTE

Sharing an office with this young woman, fluent in four languages, is THELMA PELLEY, a more recent appointee to National Office. As Nursing Secretary she is National Office's representative to the Nursing Service and Nursing Education Committees. Her activity also includes counsel to young people interested in nursing as a career and assistance to students in matters relating to both nursing service and education.

The newest member to the professional team is a non-nurse. JUNE FERGUSON was appointed public relations secretary last December. To her has been handed the task of keeping the association's public informed of its activities. She feels strongly that the CNA's most important public is its own membership. As she puts it, "if

JUNE FERGUSON

our own members are well-informed then the communities they touch will also be well-informed."

No organization can get along without a business manager. National Office feels fortunate in having GEORGINA LAMONT as their's. She creates calm out of what could be chaos with the volume of agendas, minutes and reports that are required for the many meetings held each year. For instance, in preparation for a biennial meeting roughly 2,000 copies of the president's report, the executive director's report and committee reports (which could run anywhere from 50 to 80 pages) must be stencilled, run off in French and English, then collated. This is an enormous task, under Miss Lamont's able direction panic is eliminated with the even distribution of the workload to the clerical and stenographic staff well in advance.

What do they do at National Office? They are at the service of every Canadian nurse.

Men of few words are the best men. — WILLIAM SHAKESPEARE.

Nursing Profiles

A graduate of the Vancouver General Hospital, **Leora Ruth Wright**, who joined the public health nursing branch of Ontario's Department of Health in 1946, was appointed a regional supervisor late in 1962. Miss Wright obtained her bachelor's degree in nursing from the University of British Columbia and later studied public health nursing administration at the University of Toronto. In 1961 she completed requirements for her Master of Arts degree from Teachers College, Columbia University.

Her experience as a public health nurse has included staff work with the Victorian Order of Nurses; the Metropolitan Health Committee of Vancouver; health units in Brampton, Dundas, and Napanee, Ont. For a year preceding her present appointment, Miss Wright was an instructor at the Ontario Hospital, Kingston.

(Ontario Department of Heath)

LEORA WRIGHT

Doris Edwards Wright, a graduate of Moncton City Hospital, N.B. and a member of the ANPQ for 15 years, became clinical supervisor in pediatrics at the Oshawa General Hospital during 1962. Miss Wright took postgraduate work in communicable disease nursing at the Alexandra Hospital, Montreal and later studied teaching and supervision at the School for Graduate Nurses, McGill University. For two years she filled head nurse and supervisory positions at the Alexandra Hospital, before taking over the duties

DORIS WRIGHT

of head nurse and clinical instructor in the pediatric unit of Montreal's Royal Victoria Hospital.

Miss Wright took an enthusiastic interest in the activities of the Quebec association. She was a member of the Board of Examiners and of the Curriculum Committee and chairman of the Instructors' Group. She has carried this professional interest into her new position and, early this year, joined the RNAO examining board. She is currently involved in setting up a new program in pediatric affiliation within the Oshawa General Hospital.

The Registered Nurses' Association of Ontario has announced several staff changes within recent months. **Beverley Ruth (Peach) McIntyre**, a graduate of the University of Toronto School of Nursing is one of three new assistant secretaries in nursing education and service. Mrs. McIntyre spent three years as a staff nurse with the Victorian Order of Nurses, Toronto branch, before joining the staff of the General Hospital of Port Arthur. She returned to public health nursing for a one-year period with the Northumberland-Durham Health Unit, then rejoined the staff of Port Arthur's General Hospital as assistant director, nursing education. Mrs. McIntyre has taken an active part in RNAO activities for some time in such varied capacities as chairman of District No. 10 Committee on Nursing Service and Nurs-

ing Education and as a member of the working party to study fellowships for post-graduate study.

Tatiana Labekovski, a graduate of the University of Belgrade and of Cornwall's Hotel Dieu Hospital, also joined the RNAO staff during 1962. She obtained her diploma in nursing education from Queen's University in 1957, and returned to her school of nursing to act successively as science instructor, assistant director and, finally, associate director of nursing education. Mrs. Labekovski was a former secretary of the Seaway Chapter, RNAO.

Geraldine Mae McClelland, a graduate of Grace Hospital, Windsor, is the third member of the group. She obtained her bachelor of science in nursing from the University of Western Ontario. Miss McClelland has had considerable experience in service and education. She is a former director of nursing of Grace Hospital, Windsor and also served in Victoria Hospital, London as clinical instructor and as science instructor over a period of four years. As a member of the Canadian Women's Army Corps during World War II, she saw duty in this country, England and Holland, and was made a Member of the Order of the British Empire for her services. Miss McClelland has been very active in the work of RNAO District No. 1 as chairman of the finance committee, first vice-president and president of Middlesex Chapter.

NURSING WITH INHS IN THE SASKATCHEWAN REGION

L. JEAN WHITEFORD

This is the fourth article in a series describing the work of personnel of Indian and Northern Health Services.

"Nursing is a progressive art in which to stand still is to go back." This statement is very true in Indian and Northern Health Services. Changes in attitude and behavior on the part of the native people of Canada, brought about through continuous teaching by nursing and medical staff, cannot be computed easily. Emphasis is placed on helping people to help themselves, upon working *with* them rather than *for* them.

Saskatchewan Region, compared with some of the sprawling multi-province regions in INHS, appears to be "a neat little Region." It is no small task, however, to plan and conduct a health and treatment program for 23,000 Indian people scattered in small groups over roughly 240,000 square miles. Two-thirds of the Indian population live in the northern parts of the province where transportation and communication facilities are meagre.

There are two Indian Hospitals in Saskatchewan. One has a capacity of 105 beds and is located at Ford Qu'Appelle; the other at North Battleford has a capacity of 60 beds. Indian people are also admitted to non-Federal hospitals.

A home visit . . .

Every effort is being made to bring essential health and medical care to all of these people. Doctors and nurses carry out public health programs in the reserves; nursing stations provide bedside care in the station and a public health program in the community.

Maternal and Child Care

Indian birth, morbidity and mortality rates are high. Consequently, maternal and child health work comprises an important part of the total program. Numerous factors associated with the present way of life of many of the people account for the high morbidity and mortality rates among the very young.

Providing an adequate maternal and child care program is almost an insurmountable task. The young Indian mother may tell the public health nurse about her pregnancy during the first few months but many of these people are nomadic, making it difficult and often impossible to provide medical and nursing supervision on a regular basis. Indian mothers do come to the outpatient departments at the hospitals where medical examinations are made. In most of these cases, it is possible for the nurses to make regular follow-up visits in the homes. Prenatal capsules, high in iron, calcium and vitamins, are provided. A special effort is made to help the mothers to recognize the advantages of breast feeding.

. . . is appreciated — even by Baby

The leading cause of death in Indian babies is respiratory disease; the second is gastroenteritis. Early and close supervision of infants is vital. Teaching the whole family correct care of the baby is one of the primary functions of home visiting. Nutrition instruction helps to prevent or correct the all too common iron deficiency that has been the underlying cause of many deaths among infants and young children. A prolonged diet of milk alone and/or other foods deficient in iron, has been the villain. Teen-age health classes are held in some of the residential and day schools. Prenatal as well as family health classes, are conducted on reserves. For more primitive people, the nurse is best able to adjust her teaching to meet individual needs when she visits them in their homes.

Tuberculosis

The dramatic drop from 220 tuberculosis deaths per 100,000 population in 1953, to 28.8 in 1960 tells the story of an intensive health program. Mortality and morbidity rates are higher in the northern areas than in the south. It is not always possible for staff to follow all post-sanatoria patients as they would like to do because of transportation problems and the nomadic nature of the northern bands. Locating cases of tuberculosis and following up contacts and ex-sanatorium patients are important aspects of the duties of all personnel.

Public health nurses stress tuberculosis in their health education programs

when and where it is indicated. Films, filmstrips, posters, pamphlets and, in the north, the radio, are used. The nurse emphasizes tuberculosis control in her home visiting. All newborn babies who can be reached receive B.C.G. vaccination on or about the fifth day after birth. When possible, a tuberculin test is done six months after B.C.G. vaccination and non-converters are re-vaccinated. Tuberculin testing, B.C.G. vaccination and X-ray examination all play an important part in the tuberculosis control program for the Indian population as a whole, but emphasis is placed on the children and young adults. Elderly people who may harbor the disease, despite the fact that they may appear symptom-free, are observed closely.

It is difficult for Indian people who have been free to go where and when they please, to be confined to a hospital for long periods. Every effort is made to help them to understand the transmission of disease and the importance of early and sustained treatment.

In-service Education

Unusual demands must often be made upon personnel working alone in outlying areas. Respect for the public purse and other factors, such as sheer distance from one area of population to the next, frequently make it impossible to provide staff nurses with a normal amount of supervisory assistance. Zone conferences, attended by as many nurses as can be spared from the field at one time, are held at regular intervals. Zone headquarters are at Prince Albert, North Battleford and Fort Qu'Appelle. At some of these meetings consultants from the provincial Department of Public Health, Victorian Order of Nurses, and the School of Nursing, University of Saskatchewan, assist. At other sessions the staff analyze their own problems and discuss policies and procedures with senior INHS officers. Since education and welfare are so closely related to health, the supervisor, Indian Affairs Branch, and his superintendents, superintendents of schools, and social workers, are always invited to the conferences. Although Indian Affairs and Indian and Northern Health Services are under separate Departments of Government they serve the same people. Joint sessions at regular intervals ensure efficient functioning for both groups. Inter-departmental meetings concerning such problems as housing, broken families, sanitation, or water supply, are common.

A newsletter to which all members of staff have a responsibility to contribute from time to time, has proved a useful medium for drawing attention to current topics of importance to the work. It also serves to lessen the feeling of isolation of staff members working alone; it helps them to be more conscious of belonging to a large group sharing the same broad objectives.

Health Education

Chiefs and counsellors hold hereditary offices on some reserves and are elected on others. They comprise the local governments. Indian and Northern Health Services' personnel recognize these controlling groups and enjoy working with them. One joint project was a Safe Water Poster Competition to promote interest in maintaining a safe water supply on the reserve and in the homes. Indian committees were organized to sponsor the competition in their respective communities. The results were very gratifying.

Sets of informative material concerning the competition were distributed to the chiefs and counsellors, superintendents and assistant superintendents of Indian Affairs, teachers and social workers. The Hudson's Bay Company and the free traders displayed the advertising material in their stores and offices. The Sanatoria, Y.W.C.A. and Y.M.C.A. in the cities, notified the Indian people about the competition. The nurses assisted the teachers with health education material on safe water such as films, film-strips, pamphlets and other teaching aids. The National Film Board provided extra films. The teachers included health teaching about safe water in their classes. The Health Education Division of the provincial Department of Public Health assisted by printing a very simple pamphlet and by distributing literature. Many hundreds of posters were produced and judged locally. Two hundred were entered for the grand prize. The details in the posters illus-

trated keen powers of observation. Some of them were highly artistic; many demonstrated the love for bright colors.

Evaluating projects of this kind in terms of change of behavior and attitude is interesting. In one area, after the teacher's class on safe water, the children refused to drink from the local supply, the Saskatchewan River, much to the disgust of some of the older people who had not yet been reached by the educational program.

Conclusion

Indian people have intelligence, a surprising and delightful sense of humor, and great interest in other people. Most of them realize that the "health services" are for their benefit. Gradually they are learning to help themselves to health.

(Continued from page 328)

attack on common problems by nurses functioning in comparable positions in many parts of Canada.

Initial consideration in the two-week program will be given to vital dimensions of the organization and the individual who functions in it, with a view to developing a concept of the administrative process, the functions of the administrator and how these contribute toward the achievement of individual and organizational goals. Considerable thought will be given to the skills of the administrator, both those which underlie effective behavior in any undertaking and those specific to a particular undertaking. Emphasis will be placed on the dynamics of human behavior as related to individuals and groups and the bases of positive human interaction. Within this theoretical framework considerable time will be set aside for a workshop approach to the solution of problems existent in the particular fields of nursing represented, with expert consultation available to assist in working toward their solution. Final consideration will be given to criteria of success in administration, evaluation of its attainment and the selection and development of future administrators.

The course will be conducted through lecture, discussion, case method, laboratory sessions and individual study with specific guides to resource material. Large and small group sessions will be so arranged that nurses attending will have the opportunity to study and think together, at times solely with those functioning in their own area of nursing, at other times with those in several related areas of nursing. Experts in nursing service and nursing education administration will function as resource personel throughout. While the planned program is full and concentrated, interesting leisure activities will also be included.

The program is intended to present a challenging overview of administration and to fulfill one of the evident needs for in-service growth for nurses in Canada. It is hoped that those who attend will find renewed strength and new resources within themselves through having thought about their professional life when facing it and about its inherent problems when entrusted with the responsibility for seeking their solution. The Dean and Faculty of the School of Nursing are pleased that support from the W. K. Kellogg Foundation, which has promoted the School's graduate program in nursing administration from its inception, now makes this venture in continuing education possible.

Reference

1. Sir Richard Livingstone, *Education for a World Adrift*. The Macmillan Co. 1945, p. 142.

A $250 scholarship will be awarded annually, in memory of the late Margaret Cogswell, R.N., to a member of the AARN pursuing full-time study in nursing at the University of Alberta. The award will be based on previous academic record and will be made on October 1 of each year, on recommendation of the University of Alberta School of Nursing to the Scholarship Committee. The terms will be published in the appropriate university calendars.

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The alumnae association of Royal Victoria Hospital, Montreal pays tribute to the memory of: **Katherine E. (Mackay) Paoli** '43 and **Barbara A. Tate** '55.

* * *

Evelyn Lovelace Perchard (Montreal General Hospital '05) died in Magog, P.Q. on January 9, 1963. She was in her 88th year.

* * *

Dora Purdon (Ross Memorial Hospital, Lindsay, Ont. '41) died late in 1962. She had engaged in public health nursing.

* * *

Ingeborg (Sorensen) Sage (Edmonton General Hospital '34) died during September 1962. She was a former matron of the Three Way Chronic Convalescent Hospital, Rimbey, Alta. and, at the time of her death, she was matron of Consort Municipal Hospital, Alta.

* * *

Sister Elizabeth Daly (Hotel Dieu Hospital, Montreal '20) died in Montreal late last December. She was in her 86th year.

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Sister M. Francis Joseph (St. Joseph's Hospital, Guelph, Ont. '36) died in Guelph late last year. She was engaged in institutional nursing.

* * *

Sister Rita Gagné (Hôpital Ste Croix, Drummondville '53) died on December 15, 1962.

* * *

Sister Lydia Quenneville (Notre Dame Hospital, Montreal '07) died November 19, 1962. She registered with the AARN in its first year of incorporation, 1916. Sister served in various capacities in Holy Cross Hospital, Calgary; Youville Indian Residential School, St. Albert; Blue Quill Indian School and St. Theresa's Hospital, St. Paul. From 1947 until her unofficial retirement in 1957, she was in charge of the infirmary, Youville Home, St. Albert. She was 84 years of age.

* * *

Wilhemina G. Stewart (Strathroy General Hospital, Ont. '23) died during 1962. She had engaged in private nursing.

* * *

E. B. Catherine Tilyard (Connaught Training School, Weston '32) died in Toronto late in 1962. Miss Tilyard served with the RCAMC during World War II in Newfoundland and with No. 10 Canadian General Hospital. For the past 17 years she was on the staff of Christie Street Hospital and, later, Sunnybrook Hospital, Toronto.

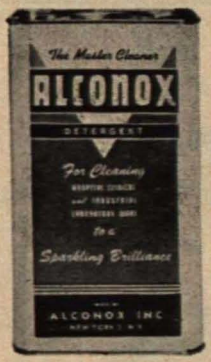
About Books

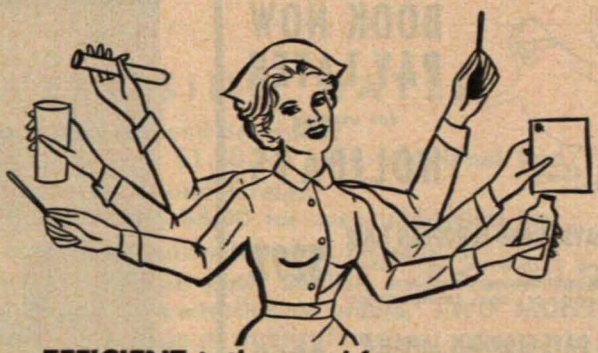
Basic Nutrition and Diet Therapy for Nurses by Lillian Mowry, B.S. 264 pages. The C. V. Mosby Company, St. Louis, Mo. Ed. 2. 1962.

"The object of this book is to give all students in the nursing and medical fields a practical knowledge of good nutrition and some knowledge of diet therapy. It furnishes a background of adequate and acurate information on basic nutrition and the dietary treatment of the more common diseases."

Childbirth by W. C. W. Nixon, M. D. 106 pages. Penguin Books Inc., 3300 Clipper Mill Road, Baltimore 11, Md. 1961.

The author attempts to explain, in simple terms, some of the facts which "have an





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important bearing on the process of birth."

The contents include: Diagnosis of pregnancy; development of the baby; prenatal care; diet and weight control; training for childbirth; minor ailments of pregnancy; delivery day.

Nurses Handbook of Current Drugs by Richard D. Tonkin, M.D., F.R.C.P. 251 pages. Wm. Heinemann Medical Books Ltd., London. 1961.

The drugs presented in this text are listed in groups with the usual name, chemical name, and proprietary name for each. The origin, actions, and effects of each drug are given in a clear, concise fashion.

This text would be of limited use to nurses in Canada since there is a difference in the proprietary names of many drugs.

Principles for First Aid for the Injured by H. Proctor, M.B., B.S., F.R.C.S.E., and P. S. London, M.B.E., M.B., B.S., F.R.C.S. 244 pages. Butterworth & Co., 1367 Danforth Avenue, Toronto 6, Ontario. 1962.

This book would be of interest to nurses, and to first aid lecturers. It provides up-to-date information concerning the early treatment of shock, hemorrhage, fractures, burns, injuries of the chest, abdomen, head, pelvis and spine.

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General Duty Nurses. Starting salary: $300 per mo., 40 hr. work wk. Room, board & laundry, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

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General Duty Nurses starting salary $315, 9, $5.00 increases to max. of $360. Experience recognized at $5.00/year up to 3 years. Alberta Blue Cross and M.S.I. benefits. Please apply to: Mrs. P. Landry, Matron, Box 520, Fairview, Alberta. 1-37-1

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General Duty Nurses for active 30-bed hospital. RNABC policies and schedules in effect also Northern allowance. Accommodations available in residence. Apply: Director of Nursing, General Hospital, Fort Nelson, British Columbia. 2-23-1

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $320 to $387. Preplanned shift rotation, B.C. registration essential, 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia. 2-32-1

General Duty Nurses for 27-bed hospital situated in the Scenic Fraser Canyon, 4 hours from Vancouver. Salary and benefits as per RNABC's agreement; $305 non-registered; $320 B.C. registered. Nurses' residence available. MSA Medical. Apply: Administrator, St. Bartholomew's Hospital, Lytton, British Columbia. 2-39-1

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Registered Nurse for General Duty in 10-bed hospital. Starting salary $335/m, $15 increase after 6 mo. 2 annual increments of $10 thereafter. 3-wk. vacation with pay after 1 yr. service, room and board $50/m, sick leave, and uniforms laundered free. Apply to: Secretary-Treasurer, Box 235, Fisher Branch, Manitoba. 3-23-1

Graduate Nurses (4 or more immediately). Basic salary: $305 plus allowance for past experience. $5.00 increments every 6 mo. Separate residence with room and board available at $45 per mo. Free laundry of uniforms. Group insurance available. Apply: The Administrator, or, The Matron, The Altona Hospital District No. 24, P.O. Box 600, Altona, Manitoba. 3-1-1

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Those interested in positions at the following locations should write to: Fisher River Hospital, HODGSON, MAN.; Miller Bay Hospital, PRINCE RUPERT, B.C.; Moose Factory Hospital, MOOSE FACTORY, ONT; Norway House Hospital, NORWAY HOUSE, MAN.; Sioux Lookout Indian Hospital, SIOUX LOOKOUT, ONT.; Nanaimo Indian Hospital, NANAIMO, B.C.

Information on these and other positions is available from Medical Services Directorate, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

Director, Personnel Services,

DEPARTMENT OF NATIONAL HEALTH AND WELFARE, OTTAWA

NEWFOUNDLAND

Registered Nurses for General Duty and Operating Room for 100-bed hospital. Nfld. Gov't. salary plus $150 bonus at end of each 6-mo. service. One way transportation paid. 2-wk. paid vacation after one year, 8 statutory holidays. Apply: Miss Ella Lefever, R.N., Nurse-in-charge, Notre Dame Bay Memorial Hospital, Twillingate, Newfoundland. 5-13-1

NORTHWEST TERRITORIES

Director of Nursing for 44-bed hospital in prosperous mining town. Hospital well equipped and adequately staffed. Shortly to be surveyed for accreditation. Further information on request. Please send complete details of qualifications and experience to: Administrator, Stanton Yellowknife Hospital, Yellowknife, N.W.T. 12-11-1

NOVA SCOTIA

Director of Nursing. (Canadian Red Cross Society, Nova Scotia Division), required until September 1st, 1964. Duties include organization of home nursing courses and sickroom loan service which will require travelling throughout Nova Scotia. All employment benefits available. Complete job analysis prepared. Salary: negotiable. Apply: Mr. C. L. Illsley, Commissioner, Canadian Red Cross Society, 5257 Morris Street, Halifax, Nova Scotia. — TELEPHONE 423-7176. 6-17-9

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia. 6-21-1

ONTARIO

Assistant Director of Nursing Service for 250-bed hospital. Good salary and personnel policies. Applications may be sent to: Director of Nursing Service, Hotel Dieu Hospital, Kingston, Ontario. 7-66-1

Supervisor for new 40-bed Psychiatric Unit. Postgraduate experience and degree in nursing preferred. Apply: Miss Edith G. Young, Reg.N., Assistant Director and Administrator of the Department of Nursing, Ottawa Civic Hospital, Ottawa 3, Ontario. 7-93-5

Operating Room Supervisor with postgraduate course for active operating room in 86-bed hospital. Good salary and employee benefits. Apply to: Director of Nursing, General and Marine Hospital, Collingwood, Ontario. 7-31-1

Operating Room Supervisor with postgraduate training, for 145-bed active General Hospital in Ottawa Valley. Personnel policies include 5-day wk., 60 days cumulative sick leave, 3-wk. vacation, 8 statutory holidays, employer participation in Pension and Life Insurance Plans. Send applications to: Miss E. I. Sheppard, Reg. N. Director of Nursing, The Cottage Hospital, Pembroke, Ontario. 7-98-1

Nursing Supervisors Registered Nurses and Cert. N. Ass'ts. Positions available on staff of 90-bed hospital. Community favorably located, 50-mi. south-west of Ottawa, 60-mi. north-east of Kingston; population 10,000. Apply to: Director of Nursing Service, St. Francis General Hospital, Smiths Falls, Ontario. 7-120-1

Clinical Instructors Medical and Surgical Nursing needed. Please write: stating education and experience to: Director of Nursing, Toronto East General Hospital, Toronto 6, Ontario. 7-133-43

Dietitian for 107-bed hospital, good salary, 40-hr. wk., excellent personnel policies. Apply: St. Vincent de Paul Hospital, Brockville, Ontario. 7-18-3

Registered Nurses for 100-bed General Hospital, salary $340 with four $10 increments, OHA pension plan in effect, good personnel policies, accommodation in residence if desired. For particulars apply to: The Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses for 34-bed hospital, min. salary $340, 3-wk. vacation with pay, sick leave after 6-mo. service. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hopsital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,000. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone: TAylor 6-3251. 7-74-1

Registered Nurses for 30-bed active General Hospital, 45-mi. from Toronto. 40-hr. wk., O.H.S.C. and P.S.I., 50% payment by hospital, Hospitals of Ontario Pension Plan, 18-day sick leave/yr. For further information apply to: Superintendent, Community Memorial Hospital, Port Perry, Ontario. 7-109-1

Rgeistered Nurses, general floor duty, rotating shifts. Modern residence accommodation. Basic salary: $350 with 6 monthly increments for 2 yrs. Room and board (maintenance) $45. Apply to : Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

Registered Nurses and Certified Nursing Assistants for modern 64-bed General Hospital. Apply to: Director of Nursing, Arnprior and District Memorial Hospital, Arnprior, Ontario. 7-4-1

Registered Nurses & Certified Nursing Assistants for modern 75-bed hospital. Starting salaries — R.N.'S $310 per mo., C.N.A.'S $220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

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Registered Nurses and Certified Nursing Assistants for 26-bed hospital. R.N. minimum salary $340, maximum $380, 28-day vacation after 1-yr. C.N.A. minimum salary $244, maximum $275, good personnel policies, 2-wk. vacation after 1-yr., 3-wk. after 2 yrs. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario. 7-87-1

Registered Nurses for General Duty in all departments including premature and new-born nursery, Isolation Emergency and Recovery Room. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $325 per mo.** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario. 7-127-4

Registered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 140 miles north of Sault Ste. Marie, Ontario. Starting salary $310 min. to $360 max., less $20 per mo. maintenance. Recognition for experience up to 3 years. Good accommodations & personnel policies. Transportation allowance after 6-mo. **Operating Room Nurse** starting salary $364 min. with postgraduate course to $414 max. with recognition for experience. Apply: Superintendent of Nurses, Lady Dunn Hospital, Wawa, Ontario. 7-140-1

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General Duty Nurses for an accredited 66-bed hospital. Starting salary: $325. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for new 70-bed hospital in Muskoka District. Starting salary $305/m., good personnel policies. Apply: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario. 7-59-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $315-$345 per mo., Graduates $250-$295; 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $300 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General and Marine Hospital, Collingwood, Ontario. 7-31-1

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment. 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, **Meaford,** Ontario. 7-79-1

Operating Room Nurse for modern 75-bed General Hospital, good personnel policies with consideration for past experience. For complete information, please write, wire or telephone to: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1A

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat, and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Public Health Nurses (Qualified) generalized program. Minimum salary $3,900; annual increment $150, liberal transportation allowance and other benefits. Apply to: A. E. Thoms M.D., Director, Leeds and Grenville Health Unit, Brockville, Ontario. 7-18-4

Public Health Nurses (qualified) Salary $3,900 to $4,900, annual increment $200, car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Box 337, Cobourg, Ontario. 7-28-4

Public Health Nurses (Qualified) for generalized program required by Stormont, Dundas and Glengarry Health Unit, located in the Seaway Valley Area. Minimum salary $3,700, annual increment, allowance for experience, 5-day wk., P.S.I. coverage, medical, surgical and obstetrical plan, employer-shared group insurance, pension plan and Ontario Hospital insurance, 3-wk. vacation, cumulative sick leave credits, one-half paid as bonus when leaving after 3 year service. Generous car allowance. Apply in writing to: Miss Glenna French, Supervisor of Nurses, Box 1058, Cornwall, Ontaro. 7-34-5

Public Health Nurse(s) (Qualified) for a generalized program in Etobicoke Township. Minimum salary $4,045, car allowance $670/annum, 4-wk. vacation after one year. The usual employee benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Road, Etobicoke, Ontario. 7-41-2

Public Health Nurse (Qualified) for generalized program. Minimum salary $3,900 with annual increments, and allowance made for experienced nurses. Apply to: Supervisor of Nursing, Fort William and District Health Unit, 900 Arthur Street, Fort William, Ontario. 7-47-4

Public Health Nurses (Qualified) for generalized program. Basic salary $3,900, good personnel policies, car expense allowance, hospitalization and Blue Cross 50% employer paid, group insurance and Pension Plan. Apply to: Dr. R. M. Aldis, Medical Officer of Health, Huron County Health Unit, Box 1060, Goderich, Ontario. 7-51-2

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Public Health Nurse (qualified) for generalized program. Salary range $4,000 to $5,000. Car provided, pension plan, attractive personnel policies. Cost of travelling to Kenora provided. Apply to: Mr. D. T. McLeod, Northwestern Health Unit, Box 250, Kenora, Ontario. 7-64-3

Public Health Nurses (qualified) for generalized program. Salary $3,900 - $4,875, annual increment $195, allowance for previous experience, car allowance, pension plan and other benefits available. Personnel policies on request. Apply to: Miss Beatrice Whalley, Supervisor of Public Health Nursing, Waterloo County Health Unit, 109 Argyle Street South, Preston, Ontario. 7-68-5

Public Health Nurses (2) for generalized public health program. Min. salary $3,900 plus allowance for experience. 4-wk. vacation, car allowance, pension plan, hospitalization, P.S.I., and group insurance available. Apply stating qualifications to: Dr. W. K. G. Allan, Director and Medical Officer of Health, Norfolk County Health Unit, Box 247, Simcoe, Ontario. 7-118-2

Public Health Nurses (qualified) for generalized nursing service. Salary range: $3,800-$4,750 based on experience. Apply to: Dr. J. M. McGarry, M.O.H. St-Catharines-Lincoln Health Unit, St. Catharines, Ontario. 7-111-4

Public Health Nurses for generalized program, salary range $3,920-$4,760 (minimum based on experience). Good personnel policies, 3-wk. vacation, accumulative sick leave, pension plan and other benefits. Apply to: Dr. J. Howie, Director, Metropolitan Windsor Health Unit, 2090 Wyandotte Street East, Windsor, Ontario. 7-145-8

Staff Nurses for all nursing units of a 325-bed, fully accredited General Hospital located in downtown area. Orientation and in-service program. Rotating hours of duty. Attractive salary & fringe benefits. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

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Operating Room Supervisor for modern, accredited 55-bed hospital. 40-hr. wk., 1-mo. vacation. Living accommodation available in new motel-style nurses' residence. Apply stating qualifications to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1

Night Supervisor for Shriners Hospital for Crippled Children, excellent personnel policies. Apply: Miss Flora M. Lamont, Administrator, Tel.: 842-4464, Montreal, Que. 9-47-42

Registered Nurses and Certified Nursing Assistants for modern 55-bed General Hospital, salary $300 per mo., 5 semi-annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $210, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1A

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Superintendent of Nursing Services for fully modern 27-bed hospital. Nursing Staff complete, two physicians on Medical Staff. Salary commensurate with qualifications and experience. Suite in residence apart from hospital. Pension plan, daily bus and rail service to Regina. Daily rail service to Winnipeg. Near summer resort. Position open on or about April 1, 1963. Apply to: Secretary-Manager, Kipling Memorial Union Hospital, Kipling, Saskatchewan. 10-59-1

Matron and Graduate Nurse for 8-bed hospital in Southern Sask. Salary range for Matron $378-$473; R.N. $320-$400. Qualifications and experience considered. Duties to commence Jan. 1/63. 3-wk. vacation plus statutory holidays, 40-hr. work wk., modern residence on grounds. Apply to: Mrs. D. L. Knops, Sec.-Treas., Rockglen Union Hospital, Rockglen Saskatchewan. 10-110-1

Registered Nurse (immediately) for Union Hospital, Mossbank, Sask., with Dr. J. T. Stockings in attendance, salaries as per SRNA with increments and benefits. 40-hr. wk., fully modern nurses' residence, daily bus service to the city. Apply to: Mrs. A. Haug, Matron, Mossbank, Saskatchewan. 10-88-1

Registered Nurses (5 immediately) for Notre Dame Hospital. Apply to: Director of Nursing, Notre Dame Hospital, North Battleford, Saskatchewan. 10-94-1

Registered or Graduate General Duty Nurses for 25-bed hospital. Salary as per SRNA policy: $300, room and board: $1.15 per day. 5 day, 40-hr. wk. No split shifts. Evening and night shift with extra pay if out of ordinary rotation. 9 statutory holidays, 3 wk. vacation. Free laundry, modern nurses' residence near hospital with TV — 2 channels. Phone: 2-2668 days, 2-2551 evenings or write: Mrs. Janie Sutherland, Superintendent of Nurses, Union Hospital, Eston, Saskatchewan. 10-33-1

Registered Nurses for General Duty, nursing positions available June 1st. This active community, located in Saskatchewan's northwest, a rolling land of bluffs, forest and lake resorts, is presently completing plans for a new 46-bed hospital. The basic salary for Registered Nurses is $300/m, living accommodation is available in the nurses' residence. All personnel policies are in accord with SRNA recommendations. Further information and applications may be directed to: Mrs. A. Shattuck, Superintendent of Nursing, Union Hospital, Meadow Lake, Saskatchewan. 10-80-1

U. S. A.

Registered Nurses for General Duty for 21-bed hospital in scenic southeastern Alaska. Apply. General Hospital, Petersburg, Alaska. 15-2-4

Staff and Head Nurses for 100-bed hospital located in the pleasant San Joaquin Valley. Starting salary $395 for Staff Nurses; $415 for Head Nurses; $10 differential for evening and nights. Liberal fringe benefits, modern nurses' residence on grounds at $10/m. Call collect or write: Director of Nursing, County Hospital, Tulare, California. 15-5-44

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Registered Nurses immediate openings in modern 300-bed hospital building. Starting salary $365/m., 5-day 40-hr. wk., liberal vacation and fringe benefits, paid insurances cafeteria. Contact: Mrs. Dorothea Stuart, Personnel Director, Fresno Community Hospital, Fresno 15, California. 15-5-17

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

Registered Nurses: Want to try the Land of Sunshine? Visit Hollywood and Disneyland? Swim all year 'round? Then work at Los Angeles (Calif.) County General Hospital where low-cost housing and meals let you save for a year long vacation! Starting salary $432; $455 in 6 months. Promotions rapid, good in-service program. Friends may have same days off. Write for full details, including information about California Registration. Director of Nursing, Room 2138, Los Angeles County General Hospital, 1200 No. State Street, Los Angeles 33, California. 15-5-3D

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Registered Nurses excellent employment opportunities in one of the largest, most modern, and well-equipped voluntary (non-profit) hospitals in California. Its location, in beautiful Sacramento, offers unlimited entertainment and recreational facilities, and is the hub of all summer and winter sports activities. Starting salaries: General Duty $410/m. days, $435/m. P.M.'s and nights. $10/m. differential for psychiatry, Operating Room $435/m. days, $460/m. P.M.'s and nights. Liberal fringe benefits including paid vacations, sick leave and holidays, free hospitalization insurance, employee discounts. Social Security, plus a retirement plan which includes free life insurance. Write: Personnel Department, Sutter Community Hospitals, 2820 "L" Street, Sacramento 16, California. 15-5-43

Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from $355-$435, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leaves and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

General Duty Staff Nurses for large General Hospital, located in college community, central California. Starting salary: $413 per mo. Excellent in-service education program, liberal fringe benefits, shift differential. Apply: Personnel Director, 530 Courthouse, Stockton, California. 15-5-36

Staff Nurses for new modern 800-bed General and Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles and San Francisco, close to 3 National Parks, 2 colleges and other cultural advantages. Full maintenance available. Immediate appointment $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California. 15-5-17A

Staff Duty positions (Nurses) in private 428-bed hospital. Liberal personnel policies and salary. Differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-38

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

Professional Nurses for immediate openings in 274-bed General Hospital, liberal fringe benefits. Enjoy interesting, challenging position in the ideal climate of Santa Monica Bay. Apply: Director of Nursing, Santa Monica Hospital, 1250-16th Street, Santa Monica, California. e 15-5-40

General Duty Nurses for various departments includling surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases and fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

Registered Nurses for 74-bed air-conditioned hospital, growing community. Starting salary: $330 per mo., fringe benefits, vacation, sick leave, holidays, life insurance, hospital insurance, 1 meal furnished. Write: Hendry General Hospital, Clewiston, Florida. 15-10-1

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General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida. 15-10-3

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Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth Hewitt, R.N., Director of Nurses, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

Registered Nurses: Salary depending on experience, periodic increases, excellent personnel policies. Further information contact: Administration, Red Wing City Hospital, Red Wing, Minnesota. 15-24-4

Staff Nurses 380-bed hosp. new 120 med-surg unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks., 5 yrs. — 4 wks. Active in-service pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611. 15-32-3

Assistant Director of Nursing Service for large General Hospital, JCAH accredited. Minimum requirements M.S. plus experience as a supervisor. Job duties include such activities as interviewing, scheduling and conferencing. Excellent personnel policies. Salary open. Apply to: Director of Nursing, The Buffalo General Hospital, Buffalo, New York. 15-33-1B

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

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Staff Nurses (All Clinical Services) Base salary $350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus. Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

Hospital Nursing Consultant — State level responsibilities in consultation, education and licensure program which has won national recognition. Requirements: master's degree in nursing and experience including one year in teaching, consultation or supervision. Salary range $6,000 to $7,200, excellent retirement system, pleasant location. Enquire: Personnel Officer, Washington State Health Dept., Public Health Bldg., Olympia, Washington. 15-48-4

Staff Nurses — University Hospital wants you if you want a challenging and rewarding position in a modern expanding 320-bed teaching and research hospital located on campus. Salary $360-$422. Opportunities in clinical research, premature center, chronic renal program, open heart surgery, and physical medicine, in addition to the general services. Liberal benefits including tuition free courses after six months. Contact: University Hospital Personnel, BB-314, Seattle, Washington. 15-48-2D

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OSHAWA GENERAL HOSPITAL

Oshawa, Ontario

Requires for School of Nursing by July 1, 1963

ONE CLINICAL INSTRUCTOR IN MEDICAL NURSING

ONE CLINICAL INSTRUCTOR IN SURGICAL NURSING

with Certificate in Nursing Education

For further information, apply to:

DIRECTOR OF NURSING,
Oshawa General Hospital, Oshawa, Ontario.

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OAKVILLE, ONTARIO

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Oakville is a progressive community situated on Lake Ontario just twenty miles from the cities of Toronto and Hamilton.
Excellent salaries and personnel policies.
Modern apartment-style staff residence under construction.
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ASSISTANT DIRECTOR,

Nursing Services in the University Hospital, Saskatoon, Saskatchewan, a 550-bed hospital situated on the campus.
University preparation desirable.

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Starting Salary $330 per month - Allowance for experience - Enquiries invited - Personnel Policies on request - 40 Hour Week - 9 statutory Holidays - Room and Board - Nurses' Residence $45 per month
New Hospital to be completed very soon

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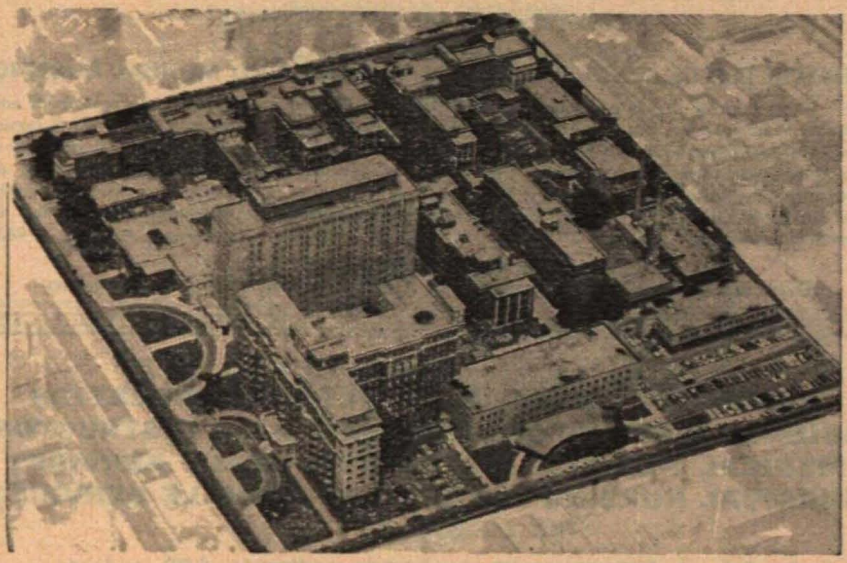
Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $375 - $462 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.
COMPETITION No. 63:101

TORONTO GENERAL HOSPITAL



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Planned Orientation Programme — Inservice Educational Programmes
Opportunity to gain additional knowledge in specialized fields of nursing
Excellent personnel policies
Salaries commensurate with prevailing current salaries in Metropolitan Toronto

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101 College Street, Toronto 2, Ontario

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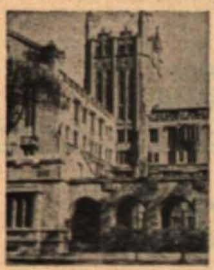

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METROPOLITAN GENERAL HOSPITAL

requires

INSTRUCTOR IN FUNDAMENTALS OF NURSING AND MEDICAL NURSING

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experiences for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Clinical and Classroom Instruction in Fundamentals of Nursing; integration of introductory Pharmacology (Solutions and Dosage); instruction within an integrated course of Medical-Surgical Nursing. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August 1, 1963.

For further information, contact:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario.

ASSISTANT DIRECTOR OF NURSING EDUCATION
SCIENCE INSTRUCTOR — NURSING ARTS INSTRUCTOR
MEDICAL NURSING INSTRUCTOR (MALE SERVICE)
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Required

For School of Nursing with maximum enrollment of 90 students.

Graduate Staff Nurses for Medical, Surgical, Pediatric and Obstetrical Service.

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A modern, progressive, 850-bed hospital located in the centre of Ontario's Golden Horseshoe, has openings for:

1) Head Nurses for Medical or Surgical units. Postgraduate study preferred
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UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week.

Salary range $300 to $360 gross per month. Differential for evening and night duty. Temporary residence accommodation if desired.

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BROCKVILLE GENERAL HOSPITAL

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TWO INSTRUCTORS

Requirements: University preparation in Nursing Education

Salary differential for degree

Apply to: **DIRECTOR OF NURSING**

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STAFF FOR GENERAL DUTY

A MEDICAL SURGICAL INSTRUCTRESS

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO.

WOODSTOCK GENERAL HOSPITAL

WOODSTOCK, ONTARIO

requires

MEDICAL CLINICAL TEACHER

Preferably with B.Sc.N. degree and experience.
Salary commensurate with qualifications and experience.

Apply to:

DIRECTOR OF NURSING
WOODSTOCK GENERAL HOSPITAL, WOODSTOCK, ONTARIO.

SCHOOL OF NURSING

METROPOLITAN GENERAL HOSPITAL

requires

INSTRUCTOR IN PEDIATRIC NURSING.

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experiences for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Clinical and Classroom Instruction in an integrated program of Maternal and Child Care. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August, 1963.

For further information, contact:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario.

CAMP DIRECTORS

Registered Nurses to direct summer camps for crippled children — June, July, August. Preference given to applicants with supervisory experience.

For further information apply to:

SUPERVISOR OF CAMPS

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REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS

are invited to enquire re: employment opportunities for all departments.
140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

DIRECTOR OF NURSING
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REQUIRES

TWO GENERAL STAFF NURSES

for
OPERATING ROOM
Preferably with experience

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"Summer Time is Sports Time" at the Lakehead

The McKellar General Hospital wants Registered Nurses and is willing to prepay costs of transportation for those nurses remaining on staff for one year. Basic salary for Registered Nurses — $325 per month. Good residence accommodation is available.
"The Hospital and the Community are friendly."

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requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL AND PSYCHIATRIC } DEPARTMENTS

Apply

EDITH G. YOUNG, REG. N.,
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KEMPTVILLE DISTRICT HOSPITAL

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REGISTERED NURSES

for General Hospital located in attractive community one hour from downtown Ottawa. Good personnel policies, employer participation in pension plan and other benefits.

Apply:

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KEMPTVILLE DISTRICT HOSPITAL
KEMPTVILLE, ONTARIO

REGISTERED NURSES
OPERATING ROOM NURSE
and
CERTIFIED NURSING ASSISTANTS

required for:

82-bed hospital. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates and personnel policies apply to:

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HALDIMAND WAR MEMORIAL HOSPITAL
DUNNVILLE, ONTARIO

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Chest Hospital in centre of Montreal
Good Personnel Policies

Apply:

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ROYAL EDWARD LAURENTIAN HOSPITAL
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CLINICAL INSTRUCTOR

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Principles and Application of Operating Room Technique

Diploma in Nursing Education and experience in the O.R. preferred. Excellent opportunity for using progressive techniques in teaching.

Position open July 1963.

This 300-bed hospital has modern classrooms and facilities. New nurses' residence. Student enrollment - 94.

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Personnel Director
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SAULT STE. MARIE, ONTARIO

Invites applications for the position of **Principal of the School of Nursing**

Hospital of 160 beds with a building extension in progress.

New modern residence and School of Nursing, accommodating 65 students in a 3 year course.

Enquiries to:

Mr. A. MIDDLEMISS
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Teaching Positions Open June, 1963

at

St. Joseph's School of Nursing
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Progressive educational program for 65 - 70 students.
Good personnel policies. BScN or Diploma in Nursing Education preferred.

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DIRECTOR OF NURSING,
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CLINICAL INSTRUCTOR

in 434-bed General Hospital; 240 students; New School and Residence Bldgs.

Experience and University preparation preferred.

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invites applications for positions of
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This branch offers experience in a diversified program including bedside nursing, individual teaching, child health centre activities, participation in experimental programs, student program, inservice education.

For details apply:

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OF MONTREAL

Positions available for Registered Nurses, general duty in a recently enlarged and modernized 273-bed General Hospital in residential area. Progressive Patient Care currently in effect with intensive intermediate and self-care units established. Positions available also in Obstetrical Department. Salaries and policies are in accordance with the recommendations of the Association of Nurses of the Province of Quebec. Differential paid for permanent evening and night duty. For further information

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An Instructor in September, 1963 for the Registered Nursing Assistants Course in a modern 86-bed hospital located 20 miles from London, Ontario. Student enrolment 20. Excellent personnel policies. Salary commensurate with education and experience.

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For complete information write to:

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REGISTERED NURSE

For

NURSE TECHNICIAN TEAM

(Intravenous Medication)

Hospitals of Ontario Pension Plan and Group Life Insurance, Shared Cost of P.S.I. and Hospital Insurance.

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Qualified Public Health Nurses for generalized Public Health Nursing Service. Salary range $4,231 - $4,787. Starting salary based on experience. Annual increments, vacation, shared hospital and medical insurance, sick pay and pension plan.

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For accredited 325-bed hospital

Qualifications:
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Supervisory experience
Salary according to qualifications

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45 BRUNSWICK AVENUE
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GENERAL STAFF NURSES

Required for

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Interesting positions immediately available for hospital of 150-beds for tuberculosis (Indians and Eskimos) and extended treatment patients. Initial salary $325 per month.

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REGISTERED NURSES
for Fall vacancies

Liberal personnel policies

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QUEENSWAY GENERAL HOSPITAL
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Required (August 1963) for

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(350 beds)

A nursing arts instructor and a clinical instructor in obstetrical nursing. Salary commensurate with preparation and experience. Liberal vacation with pay, cumulative sick leave, superannuation plan.

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Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing and the **Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.

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(b) Teaching in Schools of Nursing
(c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
DALHOUSIE UNIVERSITY, HALIFAX, N.S.

UNIVERSITY OF SASKATCHEWAN

SCHOOL OF NURSING

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Teaching and Supervision. **To prepare for positions in teaching and supervision in Schools of Nursing.**

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Credits earned may be applied toward the degree of Bachelor of Science in Nursing.

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Diploma in Nursing. **The School also conducts a three-year hospital program.**

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School of Nursing

DEGREE COURSE IN BASIC NURSING

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SCHOOL OF NURSING

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Postgraduate Courses

1. (a) **Six month clinical course in Obstetrical Nursing.**

   Classes—September and February.

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   (c) **Eight week course in Care of the Premature Infant.**

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2. **Six month course in Operating Room Technique and Management.**

   Classes—September and March.

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3. **Six month course in Theory and Practice in Psychiatric Nursing.**

   Classes—September and March.

For information and details of the courses, apply to:—

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Offers the following opportunity for advanced preparation to qualified Registered Graduate Nurses:

A six month Clinical Course

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Operating Room Principles and Advanced Practice.

The course commences in September of each year. Maintenance is provided, and a reasonable stipend is given each month. Enrolment is limited to a maximum of ten students.

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The largest eye hospital in the United States offers a six-month course in *Nursing care of the Eye* to *Graduates of Accredited Nursing Schools*, Operating Room Training is scheduled in the course.

- **Full maintenance and a stipend of $237 per month for the first three months, $247 per month for the last three months, plus maintenance.**
- ***Registration Fee is* $20**
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Director of Nurses,
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Announces the First

SCHOOL FOR SENIOR NURSING EXECUTIVES

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The program is planned to assist nursing personnel functioning in senior executive and consultant positions:

- Directors of nursing service
- Assistants and supervisors in hospitals and health agencies
- Directors and assistants of nursing education
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For further information about this program and applications write to:

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Course in public health nursing in French

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One year course offered to nurses who hold a nursing diploma from a university recognized by the School or who are licensed to practise by a professional association.

Because nurses are called upon to cooperate with other public health workers as membres of the same team, the program is planned so that all take some courses together; only particular nursing courses are attented solely by nurses.

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Offers to Graduate Nurses a Three-Month Course in *Tuberculosis Nursing*, including Immunology, Prevention, Medical and Surgical Treatment.

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2. **Demonstrations and Clinics.**
3. **Full maintenance, salary and all staff privileges.**

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NOVA SCOTIA SANATORIUM
KENTVILLE, N.S.

MONTREAL NEUROLOGICAL INSTITUTE

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Graduate Course in

1) Neurological and Neurosurgical Nursing
2) Operating Room Technique

CLASSES: Mar. 1 and Sept. 1

Students may live in or out

POSITIONS AVAILABLE

General Staff Nurses
(including operating room)

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A COURSE

in Advanced Operating Room Technique and Management

is offered by

THE MONTREAL GENERAL HOSPITAL

to

Qualified Registered Nurses

Classes of 6 months' duration are admitted March and September and are limited to 6 students.

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THE DIRECTOR OF NURSING
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MONTREAL 25, QUE.

UNIVERSITY OF NEW BRUNSWICK

SUMMER SCHOOL
FOR GRADUATE NURSES

July 2 - August 10, 1963

1. Public Health Nursing
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Apply not later than May 15 to:

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Minimum Enrollment 17 in each course

Course for GRADUATE NURSES

In operating room technique, six months. Terms begin: July 22, 1963; January 6, 1964; June 22, 1964; and December 7, 1964. Room, meals, laundering of uniforms and monthly stipend provided.

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Invites applications for

TWO INSTRUCTORS

Requirements: University preparation in Nursing Education
Salary differential for degree

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STAFF FOR GENERAL DUTY

A MEDICAL SURGICAL INSTRUCTRESS

For further information write:

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WOODSTOCK GENERAL HOSPITAL

WOODSTOCK, ONTARIO

requires

MEDICAL CLINICAL TEACHER

Preferably with B.Sc.N. degree and experience.
Salary commensurate with qualifications and experience.

Apply to:

DIRECTOR OF NURSING
WOODSTOCK GENERAL HOSPITAL, WOODSTOCK, ONTARIO.

SCHOOL OF NURSING

METROPOLITAN GENERAL HOSPITAL

requires

INSTRUCTOR IN PEDIATRIC NURSING.

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experiences for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Clinical and Classroom Instruction in an integrated program of Maternal and Child Care. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August, 1963.

For further information, contact:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario.

CAMP DIRECTORS

Registered Nurses to direct summer camps for crippled children — June, July, August. Preference given to applicants with supervisory experience.

For further information apply to:

SUPERVISOR OF CAMPS

Ontario Society for Crippled Children,
Box 1700, Postal Station "R",
350 Rumsey Road, Toronto 17,
Ontario.

REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS

are invited to enquire re: employment opportunities for all departments.
140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

DIRECTOR OF NURSING
ROSS MEMORIAL HOSPITAL
Lindsay, Ontario

WOODSTOCK GENERAL HOSPITAL

REQUIRES

TWO GENERAL STAFF NURSES

for
OPERATING ROOM
Preferably with experience

For further information write:

DIRECTOR OF NURSING
WOODSTOCK GENERAL HOSPITAL
WOODSTOCK, ONTARIO.

"Summer Time is Sports Time" at the Lakehead

The McKellar General Hospital wants Registered Nurses and is willing to prepay costs of transportation for those nurses remaining on staff for one year. Basic salary for Registered Nurses — $325 per month. Good residence accommodation is available.
"The Hospital and the Community are friendly."

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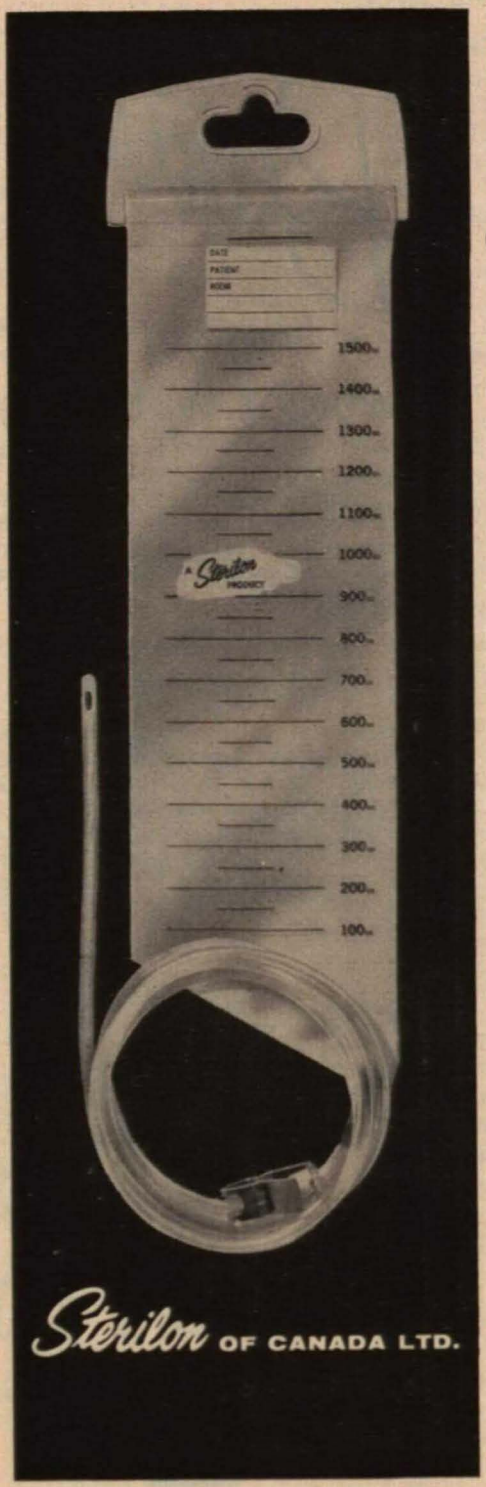

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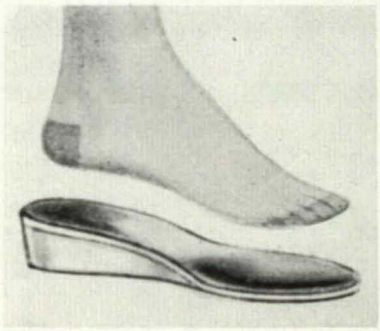

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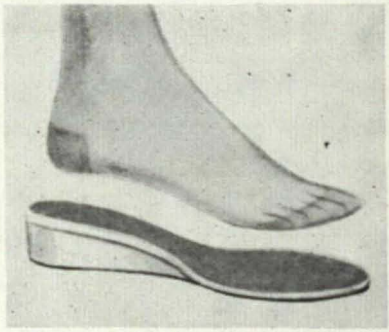

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